



**Kentucky Application
for
Provider Evaluation and
Reevaluation**

January 2009

KAPER-1 (01/2009)

Kentucky Department of Insurance

Kentucky Application for Provider Evaluation and Reevaluation – 2009

Introduction. Development of a uniform application form and guidelines for the evaluation and reevaluation of health care providers, including psychologists, was mandated under KRS 304.17 A-545 (5). In response to the requirement, the Department of Insurance developed the form entitled Kentucky Application for Provider Evaluation and Reevaluation in December 2005. The form has undergone several modifications since that time. However, the current KAPER-1 (01/2009) consists of two (2) parts, including Part A and Part B.

The KAPER-1, Part A was adopted with consent from the Council for Affordable Quality Healthcare form entitled "Provider Application." All health insurers offering managed care plans in Kentucky are required to use either the CAQH provider application or the KAPER-1 (01/2009), Part A, for the evaluation (credentialing) and reevaluation (recredentialing) of health care providers, including psychologists, who will be on their lists of participating providers. The KAPER-1 (01/2009), Part A is also used by the Cabinet for Health and Family Services (CHFS) pursuant to KRS 205.560.

The KAPER-1, Part B was initially developed in collaboration with health care providers, insurers, and the CHFS. This part is for use by Kentucky hospitals and health care facilities and consists of two (2) sections, including Part B, Section 1, used for initial evaluation (credentialing) of a physician or allied health professional, and Part B, Section 2, used for reevaluation (recredentialing) of a physician or allied health professional. The KAPER-1(01/2009), Part B is also used by the CHFS pursuant to KRS 216B.155.

The KAPER-1 (01/2009) may be accessed on the Department's Web site at <http://insurance.ky.gov> or obtained directly from the Kentucky Department of Insurance, Division of Health Insurance Policy and Managed Care, P. O. Box 517, Frankfort, KY 40602-0517. Reproduction of the form without any changes is allowed.

KAPER-1 (01/2009), Part A

**For Evaluation (Credentialing) and Reevaluation (Recredentialing) of
Health Care Providers Desiring Participation in Kentucky Managed Care
Plans and the Kentucky Medicaid Program.**

Commonwealth of Kentucky
Instructions - Form KAPER-1 (01/2009), Part A

A. Uniform Kentucky Application for Evaluation (Credentialing) and Reevaluation (recredentialing) Form. Following is the KAPER-1 (01/2009), Part A, which was adopted with consent of the Council for Affordable Quality Health Care pursuant to KRS 304.17 A-545(5). A complete KAPER-1 (01/2009), Part A, with required attachments, as specified in item C of this instruction, must be accepted by an insurer offering a managed care plan in Kentucky for the evaluation (credentialing) and reevaluation (recredentialing) of a health care provider who will be on the insurer's list of participating providers. "Health care provider" is defined in 806 KAR 17:480, Section 1. The KAPER-1 (01/2009), Part A, which must be accepted by the insurer in an electronic or handwritten format, is available on the Web site of the Department of Insurance <http://insurance.ky.gov> or at a location identified by the health insurer.

Prior to completing the KAPER-1 (01/2009), it is advised that a health care provider desiring participation in a managed care plan contact the insurer for information regarding electronic or handwritten submission of the form with required attachments, as specified in item C of this instruction, and cover letter, as applicable.

Prior to completing the KAPER-1 (01/2009), it is advised that a health care provider desiring participation in the Kentucky Medicaid Program contact the KY Cabinet for Health and Family Services for submission of required attachments, as specified in item C of this instruction, and cover letter, as applicable.

B. Cover Letter. If a complete KAPER-1 (01/2009), Part A is submitted to an insurer, a cover letter signed and dated by the health care provider requesting consideration of evaluation or reevaluation may be required by the insurer.

C. Required Attachments. Unless otherwise specified in this instruction, one (1) photocopy of each of the following eight (8) supporting documents shall be on 8 ½" X 11" paper, labeled, and attached to the complete KAPER-1 (01/2009), Part A in the following order.

1. Drug enforcement agency (DEA) registration certificate;
2. State controlled dangerous substance (CDS) certificate, if applicable;
3. W-9 of each tax identification number;
4. Workers' compensation certificate of coverage;
5. Current professional liability insurance policy face sheet (showing expiration dates, limits and health care provider's name);
6. Signed and dated authorization, attestation and release form;
7. Supplemental forms, if any, in page number order; and
8. Additional pages, if indicated (e.g. lists, etc.).

Personal Information and Professional IDs (Continued)

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

DEA EXPIRATION DATECDS EXPIRATION DATE

NO

LICENSE EXPIRATION DATE

YES

LICENSE EXPIRATION DATE

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

UPIN

MEDICAID STATEUSMLE NUMBER (WITHOUT HYPHENS)WORKERS COMPENSATION NUMBERECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY)

Section 2**Education and Training****Undergraduate School(s)**

Provide the appropriate information for the school that issued your undergraduate degree and all schools attended.

Professional School(s)

Provide the appropriate information for the school that issued your professional degree.

Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where you attended, and the Fifth Pathway institution where you completed your training on Supplemental Page 20.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Undergraduate or Professional Schools to report, use the Education Supplemental Form on page 20.

UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

START DATE

END DATE (GRADUATION DATE)

DEGREE AWARDED

DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL?

☐

YES

☐

NO

GRADUATE TYPE*:☐ U.S. OR CANADIAN GRADUATE☐ NON-U.S./CANADIAN GRADUATE☐ FIFTH PATHWAY GRADUATE**U.S. OR CANADIAN SCHOOL**

SCHOOL CODE (U.S./CANADIAN ONLY)

NAME OF U.S./CANADIAN SCHOOL:

START DATE*

END DATE (GRADUATION DATE)*

DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?

☐

YES

☐

NO

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

CITY

COUNTRY CODE

POSTAL CODE

START DATE*

END DATE (GRADUATION DATE)*

DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?

☐

YES

☐

NO

Section 2**Education and Training (Continued)****Training**

List all training programs you attended. Use one section per institution.

If you have additional post-graduate training programs, use the Supplemental Training Form on page 21.

Please explain on the Supplemental Professional / Work History Gap Form on page 33 any training gap(s) of three (3) months or greater, or any gap(s) of a shorter duration if required by the organization for which you are being credentialed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

																								SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)		
INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)																										
NUMBER				STREET																SUITE/BUILDING						
CITY												STATE		ZIP/POSTAL CODE												
COUNTRY CODE				TELEPHONE										FAX												
DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? <input type="checkbox"/> YES <input type="checkbox"/> NO																										
(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)																										

List each department separately, if applicable.

List Internship/Residency, Fellowship and Other programs separately.

<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y						M M Y Y Y Y														
START DATE												END DATE											
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)																							
NAME OF DIRECTOR																							
<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y						M M Y Y Y Y														
START DATE												END DATE											
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)																							
NAME OF DIRECTOR																							
<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y						M M Y Y Y Y														
START DATE												END DATE											
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)																							
NAME OF DIRECTOR																							

Professional / Medical Specialty Information

SPECIALTY CODE	<input type="text"/>	<input type="text"/>	<input type="text"/>	INITIAL CERTIFICATION DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	<input type="text"/>	YES	<input type="text"/>	NO
BOARD CERTIFIED?	<input type="text"/>	YES	<input type="text"/>	NO	RE-CERTIFICATION DATE (IF APPLICABLE)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	PPO	<input type="text"/>	YES	<input type="text"/>	NO
CERTIFYING BOARD CODE	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	EXPIRATION DATE (IF APPLICABLE)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	POS	<input type="text"/>	YES	<input type="text"/>	NO

SPECIALTY CODE	<input type="text"/>	<input type="text"/>	<input type="text"/>	INITIAL CERTIFICATION DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	<input type="text"/>	YES	<input type="text"/>	NO
BOARD CERTIFIED?	<input type="text"/>	YES	<input type="text"/>	NO	RECERTIFICATION DATE (IF APPLICABLE)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	PPO	<input type="text"/>	YES	<input type="text"/>	NO
CERTIFYING BOARD CODE	<input type="text"/>	<input type="text"/>	<input type="text"/>		EXPIRATION DATE (IF APPLICABLE)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	POS	<input type="text"/>	YES	<input type="text"/>	NO

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information

Primary Practice Location

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-29.

NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.

CURRENTLY PRACTICING AT THIS ADDRESS?*

☐ YES ☐ NO

PREVIOUS OR FUTURE START DATE?

M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?*

☐ YES ☐ NO

TELEPHONE*

FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID

GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)*

☐ USE INDIVIDUAL TAX ID

☐ USE GROUP TAX ID

Office Manager or Business Office Staff Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

☐

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Billing Contact.

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information (Continued)

Payment and Remittance

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION

ELECTRONIC BILLING CAPABILITIES?*

YES

NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

CHECK PAYABLE TO*

LAST NAME*

FIRST NAME*

M.I.

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE*

FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Payee Contact.

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?*

IF YES

YES

NO

ANSWERING SERVICE

VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE

VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?*

YES

NO

ACCEPT ALL NEW PATIENTS?*

YES

NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*

YES

NO

ACCEPT NEW MEDICARE PATIENTS?*

YES

NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*

YES

NO

ACCEPT NEW MEDICAID PATIENTS?*

YES

NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED)

ARE THERE ANY PRACTICE LIMITATIONS?*

YES

NO

IF YES

GENDER LIMITATIONS

MALE ONLY

NONE

AGE LIMITATIONS

MINIMUM AGE

MAXIMUM AGE

LIST OTHER LIMITATIONS

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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Section 4

Practice Location Information (Continued)

Mid-Level
Practitioners

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?

YES

NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4	Practice Location Information (Continued)			
Partners/ Associates Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided. If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.	LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE			
	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
	LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE			
	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
Covering Colleagues Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided. If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.	LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE			
	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
	LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE			
	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
	LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE			
	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

Section 5	Hospital Affiliations			
Admitting Arrangements DO YOU HAVE HOSPITAL PRIVILEGES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>			
	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>			
	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>			
	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>			
	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>			

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5

Hospital Affiliations (Continued)

Hospital Privileges

If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.

If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 30.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

PRIMARY HOSPITAL

HOSPITAL NAME																												
NUMBER					STREET															SUITE/BUILDING								
CITY										STATE					ZIP CODE													
TELEPHONE										FAX																		
DEPARTMENT NAME																												
DEPARTMENT DIRECTOR'S LAST NAME																												
DEPARTMENT DIRECTOR'S FIRST NAME																								M.I.				
M M Y Y Y Y					M M Y Y Y Y					FULL, UNRESTRICTED PRIVILEGES?					YES		NO		ARE PRIVILEGES TEMPORARY?					YES		NO		
AFFILIATION START DATE										AFFILIATION END DATE										OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?							%	
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)																												

OTHER HOSPITAL

HOSPITAL NAME																												
NUMBER					STREET															SUITE/BUILDING								
CITY										STATE					ZIP CODE													
TELEPHONE										FAX																		
DEPARTMENT NAME																												
DEPARTMENT DIRECTOR'S LAST NAME																												
DEPARTMENT DIRECTOR'S FIRST NAME																								M.I.				
M M Y Y Y Y					M M Y Y Y Y					FULL, UNRESTRICTED PRIVILEGES?					YES		NO		ARE PRIVILEGES TEMPORARY?					YES		NO		
AFFILIATION START DATE										AFFILIATION END DATE										OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?							%	
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)																												
PLEASE EXPLAIN TERMINATED AFFILIATION																												

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6

Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

IMPORTANT
IF YOU DO NOT
CARRY
MALPRACTICE
INSURANCE, CHECK
THIS BOX AND SKIP
THIS SECTION.



<input type="text"/>																				SELF-INSURED?*		<input type="checkbox"/> YES <input type="checkbox"/> NO	
CARRIER OR SELF-INSURED NAME*																							
<input type="text"/>				<input type="text"/>												<input type="text"/>							
NUMBER*				STREET*												SUITE/BUILDING							
<input type="text"/>												<input type="text"/>		<input type="text"/>									
CITY*												STATE*		ZIP CODE*									
<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>		<input type="text"/>									
ORIGINAL EFFECTIVE DATE*				EFFECTIVE DATE*				EXPIRATION DATE				TYPE OF COVERAGE?*		<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED									
<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>		<input type="text"/>									
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?*												<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ <input type="text"/>				\$ <input type="text"/>					
														AMOUNT OF COVERAGE PER OCCURRENCE				AMOUNT OF COVERAGE AGGREGATE					
POLICY INCLUDES TAIL COVERAGE?												<input type="checkbox"/> YES <input type="checkbox"/> NO											
<input type="text"/>																							
POLICY NUMBER*																							

Professional Liability Insurance Carrier

List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.

NOTE: A longer period may be required by your healthcare entity.

If you have additional Insurance, use the Supplemental Insurance Form on page 31.

<input type="text"/>																				SELF-INSURED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
CARRIER OR SELF-INSURED NAME																							
<input type="text"/>				<input type="text"/>												<input type="text"/>							
NUMBER*				STREET*												SUITE/BUILDING							
<input type="text"/>												<input type="text"/>		<input type="text"/>									
CITY*												STATE*		ZIP CODE*									
<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>		<input type="text"/>									
ORIGINAL EFFECTIVE DATE*				EFFECTIVE DATE*				EXPIRATION DATE				TYPE OF COVERAGE?*		<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED									
<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>		<input type="text"/>									
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?												<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ <input type="text"/>				\$ <input type="text"/>					
														AMOUNT OF COVERAGE PER OCCURRENCE				AMOUNT OF COVERAGE AGGREGATE					
POLICY INCLUDES TAIL COVERAGE?												<input type="checkbox"/> YES <input type="checkbox"/> NO											
<input type="text"/>																							
POLICY NUMBER*																							

Section 7

Work History and References

Military Duty

Are you currently on active military duty or military reserve?*

☐ YES ☐ NO

Work History

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity.

If you have additional work history, use the Supplemental Work History Form on page 32.

WORK HISTORY																			
<input type="text"/>																			
PRACTICE / EMPLOYER NAME																			
<input type="text"/>				<input type="text"/>												<input type="text"/>			
NUMBER				STREET												SUITE/BUILDING			
<input type="text"/>												<input type="text"/>		<input type="text"/>					
CITY												STATE		ZIP/POSTAL CODE					
<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>		<input type="text"/>					

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7

Work History and References (Continued)

Work History

Do not list current positions. Those should be listed in Section 4.

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity

If you have additional work history, use the Supplemental Work History Form on page 32.

TELEPHONE		FAX	
COUNTRY CODE	START DATE	END DATE	
REASON FOR DEPARTURE (IF APPLICABLE)			

WORK HISTORY

PRACTICE / EMPLOYER NAME	
NUMBER	SUITE/BUILDING
STREET	
CITY	STATE
ZIP/POSTAL CODE	
TELEPHONE	FAX
COUNTRY CODE	START DATE
END DATE	
REASON FOR DEPARTURE (IF APPLICABLE)	

WORK HISTORY

PRACTICE / EMPLOYER NAME	
NUMBER	SUITE/BUILDING
STREET	
CITY	STATE
ZIP/POSTAL CODE	
TELEPHONE	FAX
COUNTRY CODE	START DATE
END DATE	
REASON FOR DEPARTURE (IF APPLICABLE)	

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7

Work History and References (Continued)

Gaps in Professional / Work History

PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALLED.

GAP START DATE **GAP END DATE**

Professional References

Provide three professional references to whom you are not related or are not partners in your practice.

Code lists are found on pages 36-43. Enter the associated 3-digit code for provider type.

NOTE:

You are required to provide exactly 3 references. Your application will not be complete without this information.

Please check with
credentialing entity for
any special
requirements.

LAST NAME*																								PROVIDER TYPE (CODE PG 36)		
FIRST NAME*																										
NUMBER*				STREET*																APT/SUITE/BUILDING						
CITY*																STATE*		ZIP CODE*								
TELEPHONE										FAX																

LAST NAME*																									
FIRST NAME*																									
NUMBER*										STREET*										PROVIDER TYPE (CODE PG 36)					
CITY*										STATE*										APT/SUITE/BUILDING					
TELEPHONE										FAX										ZIP CODE*					

LAST NAME*																								PROVIDER TYPE (CODE PG 36)			
FIRST NAME*																											
NUMBER*					STREET*															APT/SUITE/BUILDING							
CITY*																						STATE*		ZIP CODE*			
TELEPHONE										FAX																	

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Section 8	Disclosure Questions
Disclosure Questions Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34. Allied Health Providers If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".	LICENSURE 1. <input type="checkbox"/> YES <input type="checkbox"/> NO Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*
	2. <input type="checkbox"/> YES <input type="checkbox"/> NO Has there been any challenge to your licensure, registration or certification?*
	HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS 3. <input type="checkbox"/> YES <input type="checkbox"/> NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
	4. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
	5. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*
	EDUCATION, TRAINING AND BOARD CERTIFICATION 6. <input type="checkbox"/> YES <input type="checkbox"/> NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*
	7. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*
	8. <input type="checkbox"/> YES <input type="checkbox"/> NO Have any of your board certifications or eligibility ever been revoked?*
	9. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*
	DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION 10. <input type="checkbox"/> YES <input type="checkbox"/> NO Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*
	MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION 11. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*
	OTHER SANCTIONS OR INVESTIGATIONS 12. <input type="checkbox"/> YES <input type="checkbox"/> NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
	13. <input type="checkbox"/> YES <input type="checkbox"/> NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*
	14. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*
	15. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*
	16. <input type="checkbox"/> YES <input type="checkbox"/> NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*
	PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY 17. <input type="checkbox"/> YES <input type="checkbox"/> NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*
	18. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

Section 8

Disclosure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

IMPORTANT
If you answered "Yes" to **question #19**, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

19. ☐ YES ☐ NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?*

If yes, provide information for each case.

CRIMINAL/CIVIL HISTORY

20. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*

21. ☐ YES ☐ NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*

22. ☐ YES ☐ NO Have you ever been court-martialed for actions related to your duties as a medical professional?*

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

ABILITY TO PERFORM JOB

23. ☐ YES ☐ NO Are you currently engaged in the illegal use of drugs?*
- ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

24. ☐ YES ☐ NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*

25. ☐ YES ☐ NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*

26. ☐ YES ☐ NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

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Professional IDs Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1

Personal Information and Professional IDs

Professional IDs

Include all additional state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/certifications.

If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.

FEDERAL DEA NUMBER

DEA ISSUE DATE

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE

FEDERAL DEA NUMBER

DEA ISSUE DATE

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE

CDS CERTIFICATE NUMBER

CDS ISSUE DATE

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE

CDS CERTIFICATE NUMBER

CDS ISSUE DATE

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE

LICENSE STATUS CODE

Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE

Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE

LICENSE STATUS CODE

Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE

Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

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Other Training Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2

Education and Training

Training

List all postgraduate training programs you attended. Use one section per institution.

If you need to report additional Training, photocopy this page as needed and submit as instructed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

															SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)		
INSTITUTION / HOSPITAL NAME (USE BOTH LINES IF REQUIRED)																	
NUMBER				STREET										SUITE/BUILDING			
CITY										STATE		ZIP/POSTAL CODE					
COUNTRY CODE			TELEPHONE						FAX								
DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? <input type="checkbox"/> YES <input type="checkbox"/> NO																	
(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)																	

List each department separately, if applicable.

List Internship/Residency, Fellowship and Other programs separately.

<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y						M M Y Y Y Y								
			START DATE						END DATE								
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)																	
NAME OF DIRECTOR																	
<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y						M M Y Y Y Y								
			START DATE						END DATE								
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)																	
NAME OF DIRECTOR																	
<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y						M M Y Y Y Y								
			START DATE						END DATE								
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)																	
NAME OF DIRECTOR																	

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE	<input type="text"/>	<input type="text"/>	<input type="text"/>	INITIAL CERTIFICATION DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	<input type="text"/>	YES	<input type="text"/>	NO
BOARD CERTIFIED?	<input type="text"/>	YES	<input type="text"/>	NO	RE-CERTIFICATION DATE (IF APPLICABLE)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		PPO	<input type="text"/>	YES	<input type="text"/>	NO
CERTIFYING BOARD CODE	<input type="text"/>	<input type="text"/>	<input type="text"/>		EXPIRATION DATE (IF APPLICABLE)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		POS	<input type="text"/>	YES	<input type="text"/>	NO

<p>IF NOT BOARD CERTIFIED (SELECT ONE)</p> <div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> <input type="checkbox"/> </div> <p>I HAVE TAKEN EXAM, RESULTS PENDING FOR</p> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <p>CERTIFYING BOARD CODE</p>	<p>I INTEND TO SIT FOR AN EXAM ON</p> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div>	<p>I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM</p> <div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> <input type="checkbox"/> </div>
---	--	---

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN. OTHERWISE LEAVE THE SPACE BLANK.

Additional Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional Specialties, photocopy this page as needed and submit as instructed.

SPECIALTY CODE	<input type="text"/>	<input type="text"/>	<input type="text"/>	INITIAL CERTIFICATION DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	<input type="text"/>	YES	<input type="text"/>	NO
BOARD CERTIFIED?	<input type="text"/>	YES	<input type="text"/>	NO	RE-CERTIFICATION DATE (IF APPLICABLE)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		PPO	<input type="text"/>	YES	<input type="text"/>	NO
CERTIFYING BOARD CODE	<input type="text"/>	<input type="text"/>	<input type="text"/>		EXPIRATION DATE (IF APPLICABLE)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		POS	<input type="text"/>	YES	<input type="text"/>	NO

<p>IF NOT BOARD CERTIFIED (SELECT ONE)</p> <div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> <input type="checkbox"/> </div> <p>I HAVE TAKEN EXAM, RESULTS PENDING FOR</p> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <p>CERTIFYING BOARD CODE</p>	<p>I INTEND TO SIT FOR AN EXAM ON</p> <div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> <input type="checkbox"/> </div> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center;">M</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center;">M</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center;">D</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center;">D</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center;">Y</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center;">Y</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center;">Y</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center;">Y</div> </div>	<p>I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.</p> <div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> <input type="checkbox"/> </div>
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IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN. OTHERWISE LEAVE THE SPACE BLANK.

T

Page 23 Std. App. v.5.0
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Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information - Page 1 of 5

Additional Practice Location

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

Office Manager or Business Office Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

Billing Contact

CHECK HERE TO
USE OFFICE
MANAGER AND
OFFICE ADDRESS
AS BILLING
INFORMATION

NOTE:

Even if you checked the boxes above, please provide the e-mail address of the Billing Contact, if available.

LOCATION* #

CURRENTLY
PRACTICING AT
THIS ADDRESS?*

YES

NO

PREVIOUS
OR FUTURE
START DATE?

M

M

D

D

Y

Y

Y

Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

SEND GENERAL
CORRESPON-
DENCE HERE?*

YES

NO

TELEPHONE*

FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID

GROUP TAX ID

PRIMARY
TAX ID
(ONE ONLY)*

USE INDIVIDUAL
TAX ID

USE GROUP
TAX ID

LAST NAME*

FIRST NAME*

M.I.

TELEPHONE*

FAX

E-MAIL ADDRESS

LAST NAME*

FIRST NAME*

M.I.

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE*

FAX

E-MAIL ADDRESS

3100

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4	Practice Location Information - Page 2 of 5																																																											
Add'l Practice Location (Cont.) Payment and Remittance YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9. <div style="border: 1px solid black; padding: 5px; width: fit-content;"> CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION </div> NOTE: Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.	<div style="border-bottom: 1px solid black; padding-bottom: 5px;"> LOCATION* # </div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;"> ELECTRONIC BILLING CAPABILITIES?* <input type="checkbox"/> YES <input type="checkbox"/> NO <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> BILLING DEPARTMENT (IF HOSPITAL-BASED) <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> <div style="width: 50%;"> <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> </div> </div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;"> CHECK PAYABLE TO* <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;"> <div style="display: flex;"> <div style="flex: 1;"> LAST NAME* <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> <div style="flex: 0.1; text-align: center;">M.I.</div> </div> <div style="display: flex;"> <div style="flex: 1;"> FIRST NAME* <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 30%;"> NUMBER* <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> <div style="width: 40%;"> STREET* <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> <div style="width: 30%;"> SUITE/BUILDING <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 60%;"> CITY* <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> <div style="width: 10%;"> STATE* <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> <div style="width: 30%;"> ZIP CODE* <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 45%;"> TELEPHONE* <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> <div style="width: 5%;">FAX</div> <div style="width: 50%;"> <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> </div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;"> E-MAIL ADDRESS <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> </div>																																																											
Office Hours NOTE: After hours back office telephone will be used only by the health plan and will not be published under any circumstances.	<div style="border-bottom: 1px solid black; padding-bottom: 5px;"> (USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR) </div> <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th></th> <th>START</th> <th>A=AM P=PM</th> <th>END</th> <th>A=AM P=PM</th> <th></th> <th>START</th> <th>A=AM P=PM</th> <th>END</th> <th>A=AM P=PM</th> </tr> </thead> <tbody> <tr> <td>MONDAY</td> <td><div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div></td> <td><div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div></td> <td><div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div></td> <td><div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div></td> <td>FRIDAY</td> <td><div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div></td> <td><div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div></td> <td><div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div></td> <td><div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div></td> </tr> <tr> <td>TUESDAY</td> <td><div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div></td> <td><div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div></td> <td><div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div></td> <td><div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div></td> <td>SATURDAY</td> <td><div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div></td> <td><div style="border: 1px solid black; display: inline-block; 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justify-content: space-between; margin-top: 5px;"> <div style="width: 30%;"> ANSWERING SERVICE <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> <div style="width: 30%;"> VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> <div style="width: 30%;"> VOICE MAIL WITH OTHER INSTRUCTIONS <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> </div> </div>											START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM	MONDAY	<div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></div>	FRIDAY	<div style="border: 1px solid black; 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Open Practice Status	<div style="border-bottom: 1px solid black; padding-bottom: 5px;"> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> ACCEPT NEW PATIENTS INTO THIS PRACTICE?* <input type="checkbox"/> YES <input type="checkbox"/> NO </div> <div style="width: 50%;"> ACCEPT ALL NEW PATIENTS?* <input type="checkbox"/> YES <input type="checkbox"/> NO </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 45%;"> ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* <input type="checkbox"/> YES <input type="checkbox"/> NO </div> <div style="width: 50%;"> ACCEPT NEW MEDICARE PATIENTS?* <input type="checkbox"/> YES <input type="checkbox"/> NO </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 45%;"> ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* <input type="checkbox"/> YES <input type="checkbox"/> NO </div> <div style="width: 50%;"> ACCEPT NEW MEDICAID PATIENTS?* <input type="checkbox"/> YES <input type="checkbox"/> NO </div> </div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;"> IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 30%;"> ARE THERE ANY PRACTICE LIMITATIONS?* <input type="checkbox"/> YES <input type="checkbox"/> NO </div> <div style="width: 30%;"> GENDER LIMITATIONS <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> MALE ONLY </div> <div> <input type="checkbox"/> NONE </div> </div> <div style="margin-top: 5px;"> <input type="checkbox"/> FEMALE ONLY </div> </div> <div style="width: 30%;"> AGE LIMITATIONS <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> MINIMUM AGE <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> <div> <input type="checkbox"/> MAXIMUM AGE <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> </div> </div> <div style="width: 30%;"> LIST OTHER LIMITATIONS <div style="border: 1px solid black; display: inline-block; width: 100%; height: 1.2em;"></div> </div> </div> </div>																																																											

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Additional Practice Location (Continued) IMPORTANT In the box provided, indicate to which practice location this page belongs.	Practice Location Information - Page 4 of 5
	<p>➔ LOCATION* # </p>
	<p>LANGUAGES</p> <p>NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> </div> <p style="text-align: center; font-size: small;">LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE</p> <p>INTERPRETERS AVAILABLE?* <input type="checkbox"/> YES <input type="checkbox"/> NO LANGUAGES INTERPRETED</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> </div> <p style="text-align: center; font-size: small;">LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE</p>
	<p>Accessibilities</p> <p>DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING</p> <p>BUILDING?* <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PARKING?* <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>RESTROOM?* <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <div style="display: flex; justify-content: space-around;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <p style="font-size: x-small;">OTHER HANDICAPPED ACCESS</p> </div> <div style="width: 30%;"> <p>DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?*</p> <p>TEXT TELEPHONY (TTY)* <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>AMERICAN SIGN LANGUAGE* <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>MENTAL/PHYSICAL IMPAIRMENT SERVICES* <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <div style="display: flex; justify-content: space-around;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <p style="font-size: x-small;">OTHER DISABILITY SERVICES</p> </div> <div style="width: 30%;"> <p>ACCESSIBLE BY PUBLIC TRANSPORTATION?*</p> <p>BUS* <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>SUBWAY* <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>REGIONAL TRAIN* <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <div style="display: flex; justify-content: space-around;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <p style="font-size: x-small;">OTHER TRANSPORTATION ACCESS</p> </div> </div>
	<p>Services</p> <p>Does this location provide any of the following services?</p> <p>LABORATORY SERVICES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)</p> <div style="display: flex; justify-content: space-around;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <p>RADIOLOGY SERVICES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE X-RAY CERTIFICATION TYPE</p> <div style="display: flex; justify-content: space-around;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 25%;"> <p>EKGs? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>DRAWING BLOOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>ASTHMA TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PULMONARY FUNCTION TESTING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> </div> <div style="width: 25%;"> <p>ALLERGY INJECTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>AGE APPROPRIATE IMMUNIZATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>OSTEOPATHIC MANIPULATION? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PHYSICAL THERAPY? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> </div> <div style="width: 25%;"> <p>ALLERGY SKIN TESTING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>FLEXIBLE SIGMOIDOSCOPY? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IV HYDRATION/ TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>CARE OF MINOR LACERATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> </div> <div style="width: 25%;"> <p>ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>TYMPANOMETRY/ AUDIOMETRY SCREENING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>CARDIAC STRESS TEST? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> </div> </div> <p>IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT CLASS/CATEGORY DO YOU USE?</p> <div style="display: flex; justify-content: space-around;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <p>IF YES, WHO ADMINISTERS IT?</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <div style="display: flex; justify-content: space-around;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <p style="font-size: x-small; text-align: center;">LAST NAME</p> </div> <div style="width: 45%;"> <div style="display: flex; justify-content: space-around;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <p style="font-size: x-small; text-align: center;">FIRST NAME</p> </div> </div> <p>TYPE OF PRACTICE (SELECT ONE ONLY)* <input type="checkbox"/> SOLO PRACTICE <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> MULTI-SPECIALTY GROUP</p> <p>ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)</p> <div style="display: flex; justify-content: space-around;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <div style="display: flex; justify-content: space-around;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div>

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4	Practice Location Information - Page 5 of 5		
Additional Practice Location (Continued)	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> LOCATION* # </div>		
IMPORTANT In the box provided, indicate to which practice location this page belongs. If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page. Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.	<div style="border: 1px solid black; padding: 5px;"> <p>LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE</p> <!-- Entry 1 --> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 70%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">LAST NAME</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">FIRST NAME</div> </div> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">M.I.</div> </div> </div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">SPECIALTY CODE</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">PROVIDER TYPE (CODE PG 36)</div> </div> <div style="width: 10%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">COVERING COLLEAGUE (Y/N)?</div> </div> </div> <!-- Entry 2 --> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 70%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">LAST NAME</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">FIRST NAME</div> </div> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">M.I.</div> </div> </div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">SPECIALTY CODE</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">PROVIDER TYPE (CODE PG 36)</div> </div> <div style="width: 10%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">COVERING COLLEAGUE (Y/N)?</div> </div> </div> <!-- Entry 3 --> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 70%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">LAST NAME</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">FIRST NAME</div> </div> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">M.I.</div> </div> </div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">SPECIALTY CODE</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">PROVIDER TYPE (CODE PG 36)</div> </div> <div style="width: 10%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">COVERING COLLEAGUE (Y/N)?</div> </div> </div> <!-- Entry 4 --> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 70%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">LAST NAME</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">FIRST NAME</div> </div> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">M.I.</div> </div> </div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">SPECIALTY CODE</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">PROVIDER TYPE (CODE PG 36)</div> </div> <div style="width: 10%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">COVERING COLLEAGUE (Y/N)?</div> </div> </div> </div>		
Covering Colleagues Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided. If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.	<div style="border: 1px solid black; padding: 5px;"> <p>LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE</p> <!-- Entry 1 --> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 70%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">LAST NAME</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">FIRST NAME</div> </div> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">M.I.</div> </div> </div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">SPECIALTY CODE</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">PROVIDER TYPE (CODE PG 36)</div> </div> </div> <!-- Entry 2 --> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 70%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">LAST NAME</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">FIRST NAME</div> </div> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">M.I.</div> </div> </div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">SPECIALTY CODE</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">PROVIDER TYPE (CODE PG 36)</div> </div> </div> <!-- Entry 3 --> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 70%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">LAST NAME</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">FIRST NAME</div> </div> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">M.I.</div> </div> </div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">SPECIALTY CODE</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">PROVIDER TYPE (CODE PG 36)</div> </div> </div> <!-- Entry 4 --> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 70%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">LAST NAME</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">FIRST NAME</div> </div> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">M.I.</div> </div> </div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 25%;"> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">SPECIALTY CODE</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">PROVIDER TYPE (CODE PG 36)</div> </div> </div> </div>		

3104

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

T

Section 5	Hospital Affiliations
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Hospital Affiliations

Professional Liability Insurance Carrier Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6

Professional Liability Insurance Carrier

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

<input type="text"/>										SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
CARRIER OR SELF-INSURED NAME											
<input type="text"/>		<input type="text"/>						<input type="text"/>			
NUMBER*		STREET*						SUITE/BUILDING			
<input type="text"/>		<input type="text"/>						<input type="text"/>		<input type="text"/>	
CITY*								STATE*		ZIP CODE*	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
ORIGINAL EFFECTIVE DATE*		EFFECTIVE DATE*		EXPIRATION DATE		TYPE OF COVERAGE?*		INDIVIDUAL		SHARED	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?		<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ <input type="text"/>		\$ <input type="text"/>					
				AMOUNT OF COVERAGE PER OCCURRENCE		AMOUNT OF COVERAGE AGGREGATE					
POLICY INCLUDES TAIL COVERAGE?		<input type="checkbox"/> YES <input type="checkbox"/> NO									
POLICY NUMBER*											

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.

<input type="text"/>										SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
CARRIER OR SELF-INSURED NAME											
<input type="text"/>		<input type="text"/>						<input type="text"/>			
NUMBER*		STREET*						SUITE/BUILDING			
<input type="text"/>		<input type="text"/>						<input type="text"/>		<input type="text"/>	
CITY*								STATE*		ZIP CODE*	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
ORIGINAL EFFECTIVE DATE*		EFFECTIVE DATE*		EXPIRATION DATE		TYPE OF COVERAGE?*		INDIVIDUAL		SHARED	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?		<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ <input type="text"/>		\$ <input type="text"/>					
				AMOUNT OF COVERAGE PER OCCURRENCE		AMOUNT OF COVERAGE AGGREGATE					
POLICY INCLUDES TAIL COVERAGE?		<input type="checkbox"/> YES <input type="checkbox"/> NO									
POLICY NUMBER*											

3106

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Training / Work History Gaps Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7

Professional Training / Work History Gaps

Professional Training / Work History Gaps

Please explain any time periods or gaps in training or work history that have occurred since graduation from professional school and are longer than three month in duration or of a shorter duration if required by the organization for which you are being credentialed.

GAP START DATE	M	M	Y	Y	Y	Y	GAP END DATE	M	M	Y	Y	Y	Y

GAP START DATE	M	M	Y	Y	Y	Y	GAP END DATE	M	M	Y	Y	Y	Y

GAP START DATE	M	M	Y	Y	Y	Y	GAP END DATE	M	M	Y	Y	Y	Y

GAP START DATE	M	M	Y	Y	Y	Y	GAP END DATE	M	M	Y	Y	Y	Y

GAP START DATE	M	M	Y	Y	Y	Y	GAP END DATE	M	M	Y	Y	Y	Y

T

Code Lists

Provider Type Codes

001	Medical Doctor (MD)	030	Licensed Practical Nurse	041	Optometrist
002	Doctor of Dental Surgery (DDS)	031	Marriage/Family Therapist	042	Pharmacist
003	Doctor of Dental Medicine (DMD)	032	Massage Therapist	043	Physical Therapist
004	Doctor of Podiatric Medicine (DPM)	033	Naturopath	044	Physician Assistant
005	Doctor of Chiropractic (DC)	034	Neuropsychologist	045	Professional Counselor
007	Osteopathic Doctor (DO)	035	Midwife	046	Registered Nurse
020	Acupuncturist	036	Nurse Midwife	047	Registered Nurse First Assistant
021	Alcohol/Drug Counselor	037	Nurse Practitioner	048	Respiratory Therapist
022	Audiologist	038	Nutritionist	049	Speech Pathologist
023	Biofeedback Technician	039	Occupational Therapist		
024	Certified Registered Nurse Anesthetist	040	Optician		
025	Christian Science Practitioner				
026	Clinical Nurse Specialist				
027	Clinical Psychologist				
028	Clinical Social Worker				
029	Dietician				

License Status Codes

001	Active	008	Pending	015	Temporary
002	Canceled	009	Probation	016	Terminated
003	Denied	010	Provisional	017	Time Limited
004	Expired	011	Restricted	018	Unrestricted
005	Inactive	012	Revoked	019	Other
006	Lapsed	013	Suspended		
007	Limited	014	Surrendered		

Country Codes

004	Afghanistan	174	Comoros	334	Heard Island and McDonald Islands	498	Moldova
008	Albania	178	Congo	340	Honduras	492	Monaco
012	Algeria	180	Congo, Democratic Republic of the	344	Hong Kong	496	Mongolia
016	American Samoa	184	Cook Islands	348	Hungary	500	Montserrat
020	Andorra	188	Costa Rica	352	Iceland	504	Morocco
024	Angola	191	Cote d'Ivoire	356	India	508	Mozambique
660	Anguilla	192	Croatia	360	Indonesia	104	Myanmar
010	Antarctica	196	Cyprus	364	Iran	516	Namibia
028	Antigua and Barbuda	203	Czech Republic	368	Iraq	520	Nauru
032	Argentina	208	Denmark	372	Ireland	524	Nepal
051	Armenia	262	Djibouti	376	Israel	528	Netherlands
533	Aruba	212	Dominica	380	Italy	530	Netherlands Antilles
036	Australia	214	Dominican Republic	388	Jamaica	540	New Caledonia
040	Austria	626	East Timor (provisional)	392	Japan	554	New Zealand
031	Azerbaijan	218	Ecuador	400	Jordan	558	Nicaragua
044	Bahamas	818	Egypt	398	Kazakhstan	562	Niger
048	Bahrain	222	El Salvador	404	Kenya	566	Nigeria
050	Bangladesh	226	Equatorial Guinea	296	Kiribati	570	Niue
052	Barbados	232	Eritrea	408	Korea, North	574	Norfolk Island
112	Belarus	233	Estonia	410	Korea, South	580	Northern Mariana Islands
056	Belgium	231	Ethiopia	414	Kuwait	578	Norway
084	Belize	238	Falkland Islands (Malvinas)	417	Kyrgyzstan	512	Oman
204	Benin	234	Faroe Islands	418	Laos	586	Pakistan
060	Bermuda	242	Fiji	428	Latvia	585	Palau
064	Bhutan	246	Finland	422	Lebanon	591	Panama
068	Bolivia	250	France	426	Lesotho	598	Papua New Guinea
070	Bosnia and Herzegovina	249	France, Metropolitan	430	Liberia	600	Paraguay
072	Botswana	254	French Guiana	434	Libya	604	Peru
074	Bouvet Island	258	French Polynesia	438	Liechtenstein	608	Philippines
076	Brazil	260	French Southern Territories	440	Lithuania	612	Pitcairn
086	British Indian Ocean Territory	266	Gabon	442	Luxembourg	616	Poland
096	Brunei Darussalam	270	Gambia	446	Macau	620	Portugal
100	Bulgaria	268	Georgia	807	Macedonia	630	Puerto Rico
854	Burkina Faso	276	Germany	450	Madagascar	634	Qatar
108	Burundi	288	Ghana	454	Malawi	638	Réunion
116	Cambodia	292	Gibraltar	458	Malaysia	642	Romania
120	Cameroon	300	Greece	462	Maldives	643	Russian Federation
124	Canada	304	Greenland	466	Mali	646	Rwanda
132	Cape Verde	308	Grenada	470	Malta	654	Saint Helena
136	Cayman Islands	312	Guadaloupe	584	Marshall Islands	659	Saint Kitts and Nevis
140	Central African Republic	316	Guam	474	Martinique	662	Saint Lucia
148	Chad	320	Guatemala	478	Mauritania	666	Saint Pierre and Miquelon
152	Chile	324	Guinea	480	Mauritius	670	Saint Vincent and the Grenadines
156	China	624	Guinea-Bissau	175	Mayotte		
162	Christmas Island	328	Guyana	484	Mexico		
166	Cocos (Keeling) Islands	332	Haiti	583	Micronesia		
170	Colombia						

Code Lists

Country Codes (continued)

882	Samoa			772	Tokelau	548	Vanuatu
674	San Marino	724	Spain	776	Tonga	336	Vatican City State (Holy See)
678	São Tomé and Príncipe	144	Sri Lanka	780	Trinidad and Tobago	862	Venezuela
682	Saudi Arabia	736	Sudan	788	Tunisia	704	Viet Nam
683	Scotland	740	Suriname	792	Turkey795 Turkmenistan	092	Virgin Islands, British
686	Senegal	744	Svalbard and Jan Mayen	796	Turks and Caicos Islands	850	Virgin Islands, U.S.
690	Seychelles	748	Swaziland	798	Tuvalu	876	Wallis and Fortuna Islands
694	Sierra Leone	752	Sweden	800	Uganda	732	Western Sahara (provisional)
702	Singapore	756	Switzerland	804	Ukraine	887	Yemen
703	Slovakia	760	Syria	784	United Arab Emirates	891	Yugoslavia
705	Slovenia	158	Taiwan	826	United Kingdom	894	Zambia
090	Solomon Islands	762	Tajikistan	840	United States	716	Zimbabwe
706	Somalia	834	Tanzania	581	U.S. Minor Outlying Islands		
710	South Africa	764	Thailand	858	Uruguay		
239	South Georgia and the South	768	Togo	860	Uzbekistan		

Language Codes

001	Abkhazian	061	Kinyarwanda	121	Tonga
002	Afan (Oromo)	062	Kirghiz	122	Tsonga
003	Afar	063	Kurundi	123	Turkish
004	Afrikaans	064	Korean	124	Turkmen
005	Albanian	065	Kurdish	125	Twi
006	Amharic	066	Laothian	126	Uigur
007	Arabic	067	Latin	127	Ukrainian
008	Armenian	068	Latvian;Lettish	128	Urdu
009	Assamese	069	Lingala	129	Uzbek
010	Zerbajjani	070	Lithuanian	130	Vietnamese
011	Bashkir	071	Macedonian	131	Volapuk
012	Basque	072	Malagasy	132	Welsh
013	Bengali;Bangla	073	Malay	133	Wolof
014	Bhutani	074	Malayalam	134	Xhosa
015	Bihari	075	Maltese	135	Yiddish
016	Bislama	076	Maori	136	Yoruba
017	Breton	077	Marathi	10	Zerbajjani
018	Bulgarian	078	Moldavian	137	Zhuang
019	Burmese	079	Mongolian	138	Zulu
020	Byelorussian	080	Nauru		
021	Cambodian	081	Nepali		
022	Catalan	082	Norwegian		
023	Chinese	083	Occitan		
024	Corsican	084	Oriya		
025	Croatian	085	Pashto;Pushto		
026	Czech	086	Persian (Farsi)		
027	Danish	087	Polish		
028	Dutch	088	Portuguese		
140	English	089	Punjabi		
030	Esperanto	090	Quechua		
031	Estonian	091	Rhaeto-Romance		
032	Faroese	092	Romanian		
033	Fiji	093	Russian		
034	Finnish	094	Samoan		
035	French	095	Sangho		
036	Frisian	096	Sanskrit		
037	Galician	097	Scot Gaelic		
038	Georgian	098	Serbian		
039	German	099	Serbo-Croatian		
040	Greek	100	Sesotho		
041	Greenlandic	101	Setswana		
042	Guarani	102	Shona		
043	Gujarati	103	Sindhi		
044	Hausa	104	Singhalese		
045	Hebrew	105	Siswati		
046	Hindi	106	Slovak		
047	Hungarian	107	Slovenian		
048	Icelandic	108	Somali		
049	Indonesian	109	Spanish		
050	Interlingua	110	Sundanese		
051	Interlingue	111	Swahili		
052	Inuktitut	112	Swedish		
053	Inupiak	113	Tagalog		
054	Irish	114	Tajik		
055	Italian	115	Tamil		
056	Japanese	116	Tatar		
057	Javanese	117	Telugu		
058	Kannada	118	Thai		
059	Kashmiri	119	Tibetan		
060	Kazakh	120	Tigrinya		

Code Lists

U.S. / Canadian Professional School Codes

Alabama

300 University of Alabama School of Dentistry
001 University of Alabama School of Medicine
002 University of South Alabama College of Medicine

Arkansas

003 University of Arkansas College of Medicine

Arizona

500 Arizona College of Osteopathic Medicine
004 University of Arizona College of Medicine

California

801 California College of Podiatric Medicine
400 Cleveland Chiropractic College of Los Angeles
005 Keck School of Medicine
401 Life Chiropractic College West
301 Loma Linda University School of Dentistry
006 Loma Linda University School of Medicine
402 Los Angeles College of Chiropractic
403 Palmer College of Chiropractic West
404 Quantum University/SCCC
007 Stanford University School of Medicine
501 Touro University College of Osteopathic Medicine
008 UCLA School of Medicine
009 University of California
010 University of California, Irvine, College of Medicine
302 University of California, Los Angeles School of Dentistry
011 University of California, San Diego, School of Medicine
303 University of California, San Francisco, School of Dentistry
012 University of California, San Francisco, School of Medicine
304 University of Southern California School of Dentistry
305 University of the Pacific School of Dentistry
502 Western University of Health Sciences, College of Osteopathic Medicine of the Pacific

Colorado

306 University of Colorado School of Dentistry
013 University of Colorado School of Medicine

Connecticut

405 University of Bridgeport College of Chiropractic
307 University of Connecticut School of Dental Medicine
014 University of Connecticut School of Medicine
015 Yale University School of Medicine

District of Columbia

016 George Washington University
017 Georgetown University School of Medicine
308 Howard University College of Dentistry
018 Howard University College of Medicine

Florida

800 Barry University School of Graduate Medical Sciences
309 Nova Southeastern University College of Dentistry
503 Nova Southeastern University College of Osteopathic Medicine
310 University of Florida College of Dentistry
019 University of Florida College of Medicine
020 University of Miami School of Medicine
021 University of South Florida College of Medicine

Georgia

022 Emory University School of Medicine
406 Life Chiropractic College
311 Medical College of Georgia School of Dentistry
023 Medical College of Georgia School of Medicine
024 Mercer University School of Medicine
025 Morehouse School of Medicine

Hawaii

026 John A. Burns School of Medicine

Iowa

802 College of Podiatric Medicine and Surgery Des Moines University
504 Des Moines University, Osteopathic Medical Center, College of Osteopathic Medicine and Surgery
407 Palmer College of Chiropractic
312 University of Iowa College of Dentistry
027 University of Iowa College of Medicine

Illinois

028 Chicago Medical School, Finch University of Health Sciences
029 Loyola University Chicago, Stritch School of Medicine
505 Midwestern University, Chicago College of Osteopathic Medicine
408 National College of Chiropractic
313 Northwestern University Dental School
030 Northwestern University Medical School
031 Rush Medical College of Rush University
804 Scholl College of Podiatric Medicine at Finch University
314 Southern Illinois University School of Dental Medicine
032 Southern Illinois University School of Medicine
033 University of Chicago, The Pritzker School of Medicine
315 University of Illinois at Chicago College of Dentistry
034 University of Illinois College of Medicine

Indiana

316 Indiana University School of Dentistry
035 Indiana University School of Medicine

Kansas

036 University of Kansas School of Medicine

Kentucky

506 Pikeville College, School of Osteopathic Medicine
317 University of Kentucky College of Dentistry
037 University of Kentucky College of Medicine
318 University of Louisville School of Dentistry
038 University of Louisville School of Medicine

Louisiana

319 Louisiana State University School of Dentistry
039 Louisiana State University School of Medicine in New Orleans
040 Louisiana State University School of Medicine in Shreveport
041 Tulane University School of Medicine

Massachusetts

042 Boston University School of Medicine
320 Boston University, Goldman School of Dental Medicine
043 Harvard Medical School
321 Harvard School of Dental Medicine
322 Tufts University School of Dental Medicine
044 Tufts University School of Medicine
045 University of Massachusetts Medical School

Maryland

046 Johns Hopkins University School of Medicine
047 Uniformed Services University of the Health Sciences
048 University of Maryland School of Medicine
323 University of Maryland, Baltimore, College of Dental Surgery

Maine

507 University of New England, College of Osteopathic Medicine

Michigan

049 Michigan State University College of Human Medicine
508 Michigan State University, College of Osteopathic Medicine
324 University of Detroit Mercy School of Dentistry
050 University of Michigan Medical School
325 University of Michigan School of Dentistry
051 Wayne State University School of Medicine

Minnesota

052 Mayo Medical School
409 Northwestern College of Chiropractic
053 University of Minnesota, Duluth School of Medicine
054 University of Minnesota Medical School, Twin Cities
326 University of Minnesota School of Dentistry

Missouri

410 Cleveland Chiropractic College of Kansas City
509 Kirksville College of Osteopathic Medicine
411 Logan Chiropractic College
055 Saint Louis University School of Medicine
510 University of Health Sciences, College of Osteopathic Medicine

056 University of Missouri, Columbia School of Medicine
327 University of Missouri Kansas City School of Dentistry
057 University of Missouri Kansas City School of Medicine
058 Washington University in St. Louis School of Medicine

Code Lists

U.S. / Canadian Professional School Codes (continued)

Mississippi

328 University of Mississippi School of Dentistry
059 University of Mississippi School of Medicine

North Carolina

060 Duke University School of Medicine
061 The Brody School of Medicine at East Carolina University
329 University of North Carolina at Chapel Hill School of Dentistry
062 University of North Carolina at Chapel Hill School of Medicine
063 Wake Forest University School of Medicine

North Dakota

064 University of North Dakota School of Medicine and Health Sciences

Nebraska

330 Creighton University School of Dentistry
065 Creighton University School of Medicine
066 University of Nebraska College of Medicine
331 University of Nebraska Medical Center, College of Dentistry

New Hampshire

067 Dartmouth Medical School

New Jersey

068 Robert Wood Johnson Medical School
069 University of Medicine and Dentistry of New Jersey (UMDNJ)
332 UMDNJ, New Jersey Dental School
511 UMDNJ, School of Osteopathic Medicine

New Mexico

070 University of New Mexico School of Medicine

Nevada

071 University of Nevada School of Medicine

New York

072 Albany Medical College
073 Albert Einstein College of Medicine
074 Columbia University College of Physicians and Surgeons
333 Columbia University School of Dental and Oral Surgery
075 Joan & Sanford I. Weill Medical College of Cornell University
076 Mount Sinai School of Medicine of New York University
412 New York Chiropractic College
512 NY College of Osteopathic Medicine of the NY Institute of Technology
077 New York Medical College
334 New York University Kraser Dental Center
078 New York University School of Medicine
335 State University of New York at Buffalo School of Dental Medicine
082 State University of New York at Buffalo School of Medicine
336 State University of New York at Stony Brook School of Dental Medicine
081 State University of New York at Stony Brook School of Medicine
079 State University of New York College of Medicine
080 State University of New York Upstate Medical University
083 University of Rochester School of Medicine and Dentistry

Ohio

337 Case Western Reserve University School of Dentistry
084 Case Western Reserve University School of Medicine
085 Medical College of Ohio
086 Northeastern Ohio Universities College of Medicine
803 Ohio College of Podiatric Medicine
338 Ohio State University College of Dentistry
087 Ohio State University College of Medicine and Public Health
513 Ohio University College of Osteopathic Medicine
088 University of Cincinnati College of Medicine
089 Wright State University School of Medicine

Oklahoma

514 Oklahoma State University, College of Osteopathic Medicine
339 University of Oklahoma College of Dentistry
090 University of Oklahoma College of Medicine

Oregon

091 Oregon Health & Science University School of Medicine
340 Oregon Health Sciences University School of Dentistry
413 Western States Chiropractic College

Pennsylvania

092 Jefferson Medical College of Thomas Jefferson University

515 Lake Erie College of Osteopathic Medicine
093 MCP Hahnemann University School of Medicine
094 Pennsylvania State University College of Medicine
516 Philadelphia College of Osteopathic Medicine
341 Temple University School of Dentistry
095 Temple University School of Medicine
805 Temple University School of Podiatric Medicine
342 University of Pennsylvania School of Dental Medicine
096 University of Pennsylvania School of Medicine
343 University of Pittsburgh School of Dental Medicine
097 University of Pittsburgh School of Medicine

Puerto Rico

098 Ponce School of Medicine
099 Universidad Central del Caribe School of Medicine
100 University of Puerto Rico School of Medicine
344 University of Puerto Rico School of Dentistry

Rhode Island

101 Brown Medical School

South Carolina

345 Medical University of South Carolina College of Dental Medicine
102 Medical University of South Carolina College of Medicine
414 Sherman College of Chiropractic
103 University of South Carolina School of Medicine

South Dakota

104 University of South Dakota School of Medicine

Tennessee

105 East Tennessee State University
346 Meharry Medical College School of Dentistry
106 Meharry Medical College School of Medicine
347 University of Tennessee College of Dentistry
107 University of Tennessee College of Medicine
108 Vanderbilt University School of Medicine

Texas

348 Baylor College of Dentistry
109 Baylor College of Medicine
415 Parker College of Chiropractic
416 Texas Chiropractic College
110 Texas Tech University Health Sciences Center School of Medicine
111 The Texas A & M University System College of Medicine
517 UNT Health Sciences Center, Texas College of Osteopathic Medicine
349 University of Texas Health Science Center at Houston Dental School
350 University of Texas Health Science Center at San Antonio Dental School
112 University of Texas Medical Branch at Galveston
113 University of Texas Medical School at Houston
114 University of Texas Medical School at San Antonio
115 UT Southwestern Medical Center at Dallas Southwestern Medical School

Utah

116 University of Utah School of Medicine

Virginia

117 Eastern VA Medical School of the Medical College of Hampton Roads
118 University of Virginia School of Medicine Health System
351 Virginia Commonwealth University School of Dentistry
119 Virginia Commonwealth University School of Medicine

Vermont

120 University of Vermont College of Medicine

Washington

352 University of Washington School of Dentistry
121 University of Washington School of Medicine

Wisconsin

353 Marquette University School of Dentistry
122 Medical College of Wisconsin
123 University of Wisconsin Medical School

West Virginia

124 Joan C. Edwards School of Medicine at Marshall University
518 West Virginia School of Osteopathic Medicine
354 West Virginia University School of Dentistry
125 West Virginia University School of Medicine

Code Lists

U.S. / Canadian Professional School Codes (continued)

Canada

355	Dalhousie University Faculty of Dentistry
126	Dalhousie University Faculty of Medicine
357	Laval University Faculty of Dentistry
127	Laval University Faculty of Medicine
356	McGill University Faculty of Dentistry
128	McGill University Faculty of Medicine
129	McMaster University School of Medicine
130	Memorial University of Newfoundland Faculty of Medicine
131	Queen's University Faculty of Health Sciences
132	The University of Western Ontario Faculty of Medicine & Dentistry
133	Universite de Montreal Faculty of Medicine
134	Universite de Sherbrooke Faculty of Medicine
358	University of Alberta Faculty of Dentistry
135	University of Alberta Faculty of Medicine
359	University of British Columbia Faculty of Dentistry
136	University of British Columbia Faculty of Medicine
137	University of Calgary Faculty of Medicine
360	University of Manitoba Faculty of Dentistry
138	University of Manitoba Faculty of Medicine
361	University of Montreal Faculty of Dentistry
139	University of Ottawa Faculty of Medicine
362	University of Saskatchewan College of Dentistry
140	University of Saskatchewan College of Medicine
363	University of Toronto Faculty of Dentistry
141	University of Toronto Faculty of Medicine
364	University of Western Ontario Faculty of Dentistry

Specialty Codes - MD / DO Only

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

247	Allergy & Immunology	287	Internal Medicine, Hematology	Spine	
246	Allergy & Immunology, Allergy	288	Internal Medicine, Hematology & Oncology	416	Orthopaedic Surgery, Orthopaedic Trauma
291	Allergy & Immunology, Clinical & Laboratory Immunology	450	Internal Medicine, Hepatology	803	Orthopaedic Surgery, Pediatric Orthopaedic Surgery
249	Anesthesiology	299	Internal Medicine, Infectious Disease	457	Orthopaedic Surgery, Sports Medicine
235	Anesthesiology, Addiction Medicine	451	Internal Medicine, Interventional Cardiology	119	Orthopedic
258	Anesthesiology, Critical Care Medicine	453	Internal Medicine, Magnetic Resonance Imaging (MRI)	331	Otolaryngology
126	Anesthesiology, Pain Medicine	325	Internal Medicine, Medical Oncology	458	Otolaryngology, Otolaryngic Allergy
363	Clinical Pharmacology	309	Internal Medicine, Nephrology	459	Otolaryngology, Otolaryngology/ Facial Plastic Surgery
367	Colon & Rectal Surgery	378	Internal Medicine, Pulmonary Disease	332	Otolaryngology, Otology & Neurotology
263	Dermatology	390	Internal Medicine, Rheumatology	357	Otolaryngology, Pediatric Otolaryngology
292	Dermatology, Clinical & Laboratory Dermatological Immunology	802	Internal Medicine, Sleep Medicine	417	Otolaryngology, Plastic Surgery within the Head & Neck
444	Dermatology, Dermatological Surgery	397	Internal Medicine, Sports Medicine	804	Otolaryngology, Sleep Medicine
266	Dermatology, Dermatopathology	433	Laboratories, Clinical Medical Laboratory	480	Pain Medicine, Interventional Pain Medicine
264	Dermatology, MOHS-Micrographic Surgery	481	Legal Medicine	337	Pain Medicine
443	Dermatology, Pediatric Dermatology	278	Medical Genetics, Clinical Biochemical Genetics	338	Pathology, Anatomic Pathology
268	Emergency Medicine	261	Medical Genetics, Clinical Cytogenetic	340	Pathology, Anatomic Pathology & Clinical Pathology
445	Emergency Medicine, Emergency Medical Services	277	Medical Genetics, Clinical Genetics (M.D.)	250	Pathology, Blood Banking & Transfusion Medicine
427	Emergency Medicine, Medical Toxicology	280	Medical Genetics, Clinical Molecular Genetics	344	Pathology, Chemical Pathology
348	Emergency Medicine, Pediatric Emergency Medicine	455	Medical Genetics, Molecular Genetic Pathology		
395	Emergency Medicine, Sports Medicine	454	Medical Genetics, Ph.D. Medical Genetics	302	Pathology, Clinical Pathology/Laboratory Medicine
446	Emergency Medicine, Undersea and Hyperbaric Medicine	306	Neonatal-Perinatal Medicine	262	Pathology, Cytopathology
391	Facial Plastic Surgery	308	Neopathology	265	Pathology, Dermatopathology
272	Family Practice	409	Neurological Surgery	273	Pathology, Forensic Pathology
447	Family Practice, Addiction Medicine	330	Neuromusculoskeletal Medicine & OMM	290	Pathology, Hematology
237	Family Practice, Adolescent Medicine	440	Neuromusculoskeletal Medicine, Sports Medicine	298	Pathology, Immunopathology
448	Family Practice, Adult Medicine	317	Nuclear Medicine	305	Pathology, Medical Microbiology
282	Family Practice, Geriatric Medicine	318	Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine	461	Pathology, Molecular Genetic Pathology
396	Family Practice, Sports Medicine	315	Nuclear Medicine, Nuclear Cardiology	312	Pathology, Neuropathology
225	General Practice	316	Nuclear Medicine, Nuclear Imaging & Therapy	358	Pathology, Pediatric Pathology
479	Hospitalist	321	Obstetrics & Gynecology	244	Pediatrics
301	Internal Medicine	260	Obstetrics & Gynecology, Critical Care Medicine	805	Pediatric Anesthesiology
449	Internal Medicine, Addiction Medicine	326	Obstetrics & Gynecology, Gynecologic Oncology	239	Pediatrics, Adolescent Medicine
236	Internal Medicine, Adolescent Medicine	286	Obstetrics & Gynecology, Gynecology		
248	Internal Medicine, Allergy & Immunology	303	Obstetrics & Gynecology, Maternal & Fetal Medicine	295	Pediatrics, Clinical & Laboratory Immunology
255	Internal Medicine, Cardiovascular Disease	320	Obstetrics & Gynecology, Obstetrics	462	Pediatrics, Developmental – Behavioral Pediatrics
294	Internal Medicine, Clinical & Laboratory Immunology	271	Obstetrics & Gynecology, Reproductive Endocrinology	354	Pediatrics, Medical Toxicology
253	Internal Medicine, Clinical Cardiac Electrophysiology	328	Ophthalmology	356	Pediatrics, Neurodevelopmental Disabilities
257	Internal Medicine, Critical Care Medicine	441	Oral & Maxillofacial Surgery	345	Pediatrics, Pediatric Allergy & Immunology
267	Internal Medicine, Endocrinology, Diabetes & Metabolism	411	Orthopaedic Surgery		
275	Internal Medicine, Gastroenterology	412	Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery		
285	Internal Medicine, Geriatric Medicine	456	Orthopaedic Surgery, Foot and Ankle Orthopaedics		
		406	Orthopaedic Surgery, Hand Surgery		
		415	Orthopaedic Surgery, Orthopaedic Surgery of the		

Code Lists

Specialty Codes - MD/DO Only

346	Pediatrics, Pediatric Cardiology	Hand	Neurology	413	Surgery, Surgical Oncology
347	Pediatrics, Pediatric Critical Care Medicine	242 Preventive Medicine, Aerospace Medicine	474 Psychiatry & Neurology, Pain Medicine	423	Surgery, Trauma Surgery
463	Pediatrics, Pediatric Emergency Medicine	429 Preventive Medicine, Medical Toxicology	368 Psychiatry & Neurology, Psychiatry	400	Surgery, Vascular Surgery
349	Pediatrics, Pediatric Endocrinology	112 Preventive Medicine, Occupational Medicine	809 Psychiatry & Neurology, Sleep Medicine	421	Thoracic Surgery (Cardiothoracic Vascular Surgery)
350	Pediatrics, Pediatric Gastroenterology	471 Preventive Medicine, Sports Medicine	475 Psychiatry & Neurology, Sports Medicine	442	Transplant Surgery
351	Pediatrics, Pediatric Hematology-Oncology	431 Preventive Medicine, Undersea and Hyperbaric Medicine	476 Psychiatry & Neurology, Vascular Neurology	424	Urology
352	Pediatrics, Pediatric Infectious Diseases	114 Preventive Medicine/Occupational Environmental Medicine	366 Public Health & General Preventive Medicine	811	Urology, Pediatric Urology
355	Pediatrics, Pediatric Nephrology	370 Psychiatry & Neurology, Addiction Medicine	252 Radiology, Body Imaging		
359	Pediatrics, Pediatric Pulmonology	473 Psychiatry & Neurology, Addiction Psychiatry	173 Radiology, Diagnostic Radiology		
361	Pediatrics, Pediatric Rheumatology	371 Psychiatry & Neurology, Child & Adolescent Psychiatry	430 Radiology, Diagnostic Ultrasound		
806	Pediatrics, Sleep Medicine	313 Psychiatry & Neurology, Clinical Neurophysiology	314 Radiology, Neuroradiology		
398	Pediatrics, Sports Medicine	274 Psychiatry & Neurology, Forensic Psychiatry	319 Radiology, Nuclear Radiology		
365	Physical Medicine & Rehabilitation	373 Psychiatry & Neurology, Geriatric Psychiatry	360 Radiology, Pediatric Radiology		
468	Physical Medicine & Rehabilitation, Pain Medicine	472 Psychiatry & Neurology, Neurodevelopmental Disabilities	380 Radiology, Radiation Oncology		
389	Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine	100 Psychiatry & Neurology, Neurology	477 Radiology, Radiological Physics		
466	Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine	311 Psychiatry & Neurology, Neurology with Special Qualifications in Child	381 Radiology, Therapeutic Radiology		
469	Physical Medicine & Rehabilitation, Sports Medicine		384 Radiology, Vascular & Interventional Radiology		
419	Plastic Surgery		434 Supplier		
470	Plastic Surgery, Plastic Surgery Within the Head and Neck		399 Surgery		
407	Plastic Surgery, Surgery of the		418 Surgery, Pediatric Surgery		
			420 Surgery, Plastic and Reconstructive Surgery		
			405 Surgery, Surgery of the Hand		
			425 Surgery, Surgical Critical Care		

Specialty Codes - DDS / DMD / DPM / DC

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

DDS / DMD	DPM	DC
2 Dentist	3 Podiatrist	1 Chiropractor
13 Dentist, Dental Public Health	231 Podiatrist, Foot & Ankle Surgery	5 Chiropractor, Internist
14 Dentist, Endodontics	230 Podiatrist, Foot Surgery	6 Chiropractor, Neurology
438 Dentist, General Practice	227 Podiatrist, Primary Podiatric Medicine	7 Chiropractor, Nutrition
16 Dentist, Oral and Maxillofacial Pathology	226 Podiatrist, Public Medicine	8 Chiropractor, Occupational Medicine
439 Dentist, Oral and Maxillofacial Radiology	228 Podiatrist, Radiology	9 Chiropractor, Orthopedic
20 Dentist, Oral and Maxillofacial Surgery	229 Podiatrist, Sports Medicine	10 Chiropractor, Radiology
15 Dentist, Orthodontics and Dentofacial Orthopedics		801 Chiropractor, Rehabilitation Specialization
17 Dentist, Pediatric Dentistry		11 Chiropractor, Sports Physician
18 Dentist, Periodontics		12 Chiropractor, Thermography
19 Dentist, Prosthodontics		

Specialty Codes - Allied Providers

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

501 Acupuncturist	753 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family
503 Audiologist	754 Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
504 Audiologist, Assistive Technology Practitioner	755 Clinical Nurse Specialist, Psychiatric/Mental Health, Community
505 Audiologist, Assistive Technology Supplier	756 Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric
531 Christian Science Practitioner	757 Clinical Nurse Specialist, Rehabilitation
727 Clinical Nurse Specialist	759 Clinical Nurse Specialist, School
728 Clinical Nurse Specialist, Acute Care	758 Clinical Nurse Specialist, Transplantation
729 Clinical Nurse Specialist, Adult Health	760 Clinical Nurse Specialist, Women's Health
730 Clinical Nurse Specialist, Chronic Care	513 Counselor
731 Clinical Nurse Specialist, Community Health/Public Health	514 Counselor, Addiction (Substance Use Disorder)
732 Clinical Nurse Specialist, Critical Care Medicine	515 Counselor, Mental Health
733 Clinical Nurse Specialist, Emergency	516 Counselor, Professional
734 Clinical Nurse Specialist, Ethics	533 Dietitian, Registered
735 Clinical Nurse Specialist, Family Health	536 Dietitian, Registered, Nutrition, Metabolic
736 Clinical Nurse Specialist, Gerontology	534 Dietitian, Registered, Nutrition, Pediatric
737 Clinical Nurse Specialist, Holistic	535 Dietitian, Registered, Nutrition, Renal
738 Clinical Nurse Specialist, Home Health	651 Licensed Practical Nurse
739 Clinical Nurse Specialist, Informatics	517 Marriage & Family Therapist
740 Clinical Nurse Specialist, Long-Term Care	547 Massage Therapist
741 Clinical Nurse Specialist, Medical-Surgical	549 Midwife, Certified
742 Clinical Nurse Specialist, Neonatal	652 Midwife, Certified Nurse
743 Clinical Nurse Specialist, Neuroscience	551 Naturopath
744 Clinical Nurse Specialist, Occupational Health	553 Neuropsychologist
745 Clinical Nurse Specialist, Oncology	653 Nurse Anesthetist, Certified Registered
746 Clinical Nurse Specialist, Oncology, Pediatrics	654 Nurse Practitioner
747 Clinical Nurse Specialist, Pediatrics	655 Nurse Practitioner, Acute Care
748 Clinical Nurse Specialist, Perinatal	656 Nurse Practitioner, Adult Health
749 Clinical Nurse Specialist, Perioperative	658 Nurse Practitioner, Community Health
750 Clinical Nurse Specialist, Psychiatric/Mental Health	657 Nurse Practitioner, Critical Care Medicine
751 Clinical Nurse Specialist, Psychiatric/Mental Health, Adult	659 Nurse Practitioner, Family
752 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent	

Code Lists

Specialty Codes - Allied Providers (continued)

660	Nurse Practitioner, Gerontology	679	Registered Nurse, Continuing Education/Staff Development
661	Nurse Practitioner, Neonatal	675	Registered Nurse, Critical Care Medicine
662	Nurse Practitioner, Neonatal, Critical Care	682	Registered Nurse, Diabetes Educator
670	Nurse Practitioner, Obstetrics & Gynecology	683	Registered Nurse, Dialysis, Peritoneal
671	Nurse Practitioner, Occupational Health	684	Registered Nurse, Emergency
663	Nurse Practitioner, Pediatrics	685	Registered Nurse, Enterostomal Therapy
664	Nurse Practitioner, Pediatrics, Critical Care	686	Registered Nurse, Flight
666	Nurse Practitioner, Perinatal	688	Registered Nurse, Gastroenterology
667	Nurse Practitioner, Primary Care	687	Registered Nurse, General Practice
665	Nurse Practitioner, Psych/Mental Health	689	Registered Nurse, Gerontology
668	Nurse Practitioner, School	691	Registered Nurse, Hemodialysis
669	Nurse Practitioner, Women's Health	690	Registered Nurse, Home Health
537	Nutritionist	692	Registered Nurse, Hospice
538	Nutritionist, Nutrition, Education	694	Registered Nurse, Infection Control
555	Occupational Therapist	693	Registered Nurse, Infusion Therapy
556	Occupational Therapist, Ergonomics	695	Registered Nurse, Lactation Consultant
557	Occupational Therapist, Hand	696	Registered Nurse, Maternal Newborn
558	Occupational Therapist, Human Factors	697	Registered Nurse, Medical-Surgical
559	Occupational Therapist, Neurorehabilitation	699	Registered Nurse, Neonatal Intensive Care
560	Occupational Therapist, Pediatrics	700	Registered Nurse, Neonatal, Low-Risk
561	Occupational Therapist, Rehabilitation, Driver	701	Registered Nurse, Nephrology
563	Optician	702	Registered Nurse, Neuroscience
565	Optometrist	698	Registered Nurse, Nurse Massage Therapist (NMT)
566	Optometrist, Corneal and Contact Management	703	Registered Nurse, Nutrition Support
567	Optometrist, Low Vision Rehabilitation	719	Registered Nurse, Obstetric, High-Risk
571	Optometrist, Occupational Vision	720	Registered Nurse, Obstetric, Inpatient
568	Optometrist, Pediatrics	721	Registered Nurse, Occupational Health
569	Optometrist, Sports Vision	722	Registered Nurse, Oncology
570	Optometrist, Vision Therapy	725	Registered Nurse, Ophthalmic
573	Pharmacist	724	Registered Nurse, Orthopedic
574	Pharmacist, General Practice	726	Registered Nurse, Ostomy Care
807	Pharmacist, Geriatric	723	Registered Nurse, Otorhinolaryngology & Head-Neck
575	Pharmacist, Nuclear	704	Registered Nurse, Pain Management
576	Pharmacist, Nutrition Support	706	Registered Nurse, Pediatric Oncology
808	Pharmacist, Oncology	705	Registered Nurse, Pediatrics
577	Pharmacist, Pharmacotherapy	710	Registered Nurse, Perinatal
578	Pharmacist, Psychiatric	714	Registered Nurse, Plastic Surgery
580	Physical Therapist	708	Registered Nurse, Psych/Mental Health
581	Physical Therapist, Cardiopulmonary	709	Registered Nurse, Psych/Mental Health, Adult
583	Physical Therapist, Electrophysiology, Clinical	707	Registered Nurse, Psych/Mental Health, Child & Adolescent
582	Physical Therapist, Ergonomics	810	Registered Nurse, Registered Nurse First Assistant
584	Physical Therapist, Geriatrics	712	Registered Nurse, Rehabilitation
585	Physical Therapist, Hand	713	Registered Nurse, Reproductive Endocrinology/Infertility
586	Physical Therapist, Human Factors	715	Registered Nurse, School
587	Physical Therapist, Neurology	716	Registered Nurse, Urology
590	Physical Therapist, Orthopedic	718	Registered Nurse, Women's Health Care, Ambulatory
588	Physical Therapist, Pediatrics	717	Registered Nurse, Wound Care
589	Physical Therapist, Sports	617	Respiratory Therapist, Certified
592	Physician Assistant	618	Respiratory Therapist, Certified, Critical Care
593	Physician Assistant, Medical	620	Respiratory Therapist, Certified, Educational
594	Physician Assistant, Surgical	619	Respiratory Therapist, Certified, Emergency Care
596	Psychologist	622	Respiratory Therapist, Certified, General Care
597	Psychologist, Addiction (Substance Use Disorder)	621	Respiratory Therapist, Certified, Geriatric Care
598	Psychologist, Adult Development & Aging	623	Respiratory Therapist, Certified, Home Health
599	Psychologist, Behavioral	628	Respiratory Therapist, Certified, Neonatal/Pediatrics
602	Psychologist, Child, Youth & Family	627	Respiratory Therapist, Certified, Palliative/Hospice
600	Psychologist, Clinical	629	Respiratory Therapist, Certified, Patient Transport
601	Psychologist, Counseling	624	Respiratory Therapist, Certified, Pulmonary Diagnostics
603	Psychologist, Educational	626	Respiratory Therapist, Certified, Pulmonary Function Technologist
604	Psychologist, Exercise & Sports	625	Respiratory Therapist, Certified, Pulmonary Rehabilitation
605	Psychologist, Family	630	Respiratory Therapist, Certified, SNF/Subacute Care
606	Psychologist, Forensic	631	Respiratory Therapist, Registered
607	Psychologist, HealthService	632	Respiratory Therapist, Registered, Critical Care
608	Psychologist, Men & Masculinity	634	Respiratory Therapist, Registered, Educational
609	Psychologist, Mental Retardation & Developmental Disabilities	633	Respiratory Therapist, Registered, Emergency Care
610	Psychologist, Psychoanalysis	636	Respiratory Therapist, Registered, General Care
611	Psychologist, Psychotherapy	635	Respiratory Therapist, Registered, Geriatric Care
612	Psychologist, Psychotherapy, Group	637	Respiratory Therapist, Registered, Home Health
613	Psychologist, Rehabilitation	642	Respiratory Therapist, Registered, Neonatal/Pediatrics
614	Psychologist, School	641	Respiratory Therapist, Registered, Palliative/Hospice
615	Psychologist, Women	643	Respiratory Therapist, Registered, Patient Transport
672	Registered Nurse	638	Respiratory Therapist, Registered, Pulmonary Diagnostics
673	Registered Nurse, Addiction (Substance Use Disorder)	640	Respiratory Therapist, Registered, Pulmonary Function Technologist
674	Registered Nurse, Administrator	639	Respiratory Therapist, Registered, Pulmonary Rehabilitation
711	Registered Nurse, Ambulatory Care	644	Respiratory Therapist, Registered, SNF/Subacute Care
681	Registered Nurse, Cardiac Rehabilitation	646	Social Worker, Clinical
676	Registered Nurse, Case Management	648	Specialist/Technologist, Other, Biomedical Engineering
677	Registered Nurse, College Health	506	Speech-Language Pathologist
678	Registered Nurse, Community Health	649	Technician, Other, Biomedical Engineering
680	Registered Nurse, Continence Care	502	Other, Not Listed

Code Lists

Specialty Boards - Allied Providers

940	Academy of Certified Social Workers	350	American Nurses Credentialing Center
1150	ACNM Certification Council	740	American Psychological Association
360	American Academy of Ambulatory Care Nursing	750	American Psychological Society
1550	American Academy of Anesthesiologist Assistants	760	American Psychotherapy Association
230	American Academy of Audiology	290	American Society of Addiction Medicine
370	American Academy of Experts in Traumatic Stress	1650	American Speech-Language-Hearing Association
270	American Academy of Health Providers in the Addictive Disorders	250	Biofeedback Certification Institute of America
200	American Academy of Medical Acupuncture	1430	Board of Pharmaceutical Specialties
405	American Academy of Nurse Practitioners	1250	Commission on Dietetic Registration
380	American Academy of Nursing	960	Employee Assistance Professionals Association
1330	American Academy of Optometry	780	National Association for the Advancement of Psychoanalysis
1480	American Academy of Physician Assistants	1450	National Association of Boards of Pharmacy
1110	American Association for Marriage and Family Therapy	1600	National Association of Nurse Anesthetists
390	American Association of Critical Care Nurses	770	National Association of School Psychologists
1590	American Association of Nurse Anesthetists	980	National Association of Social Workers
330	American Association of Pastoral Counselors	1310	National Board for Certification in Occupational Therapy
1010	American Association of Sex Educators, Counselors and Therapists	1490	National Board for Certification of Orthopaedic Physician Assistants
710	American Board Medical Psychotherapists	790	National Board for Certified Clinical Hypnotherapists
280	American Board of Addiction Medicine	310	National Board for Certified Counselors
950	American Board of Examiners in Clinical Social Work	1630	National Board for Respiratory Care
720	American Board of Medical Psychotherapists & Psychodiagnostics	300	National Board of Addiction Examiners
400	American Board of Nursing Specialties	800	National Board of Cognitive Behavioral Therapists
1240	American Board of Nutrition	1350	National Board of Examiners in Optometry
1300	American Board of Occupational Medicine	1090	National Certification Board for Therapeutic Massage and Bodywork
1360	American Board of Ophthalmology	210	National Certification Commission for Acupuncture and Oriental Medicine
1510	American Board of Physical Therapy Specialties	1440	National Institute for Standards in Pharmacist Credentialing
700	American Board of Professional Psychology	220	Other - Not Listed
1130	American Naturopath Certification Board		

Specialty Boards - MD / DDS / DMD / DO / DPM

MD Boards

044	American Board of Allergy & Immunology
045	American Board of Anesthesiology
046	American Board of Colon & Rectal Surgery
047	American Board of Dermatology
048	American Board of Emergency Medicine
049	American Board of Family Medicine
050	American Board of Internal Medicine
051	American Board of Medical Genetics
052	American Board of Neurological Surgery
053	American Board of Nuclear Medicine
054	American Board of Obstetrics & Gynecology
055	American Board of Ophthalmology
109	American Board of Oral & Maxillofacial Surgeons
056	American Board of Orthopaedic Surgery
057	American Board of Otolaryngology
058	American Board of Pathology
059	American Board of Pediatrics
060	American Board of Physical Medicine & Rehabilitation
061	American Board of Plastic Surgery
062	American Board of Preventive Medicine
063	American Board of Psychiatry & Neurology
064	American Board of Radiology
065	American Board of Surgery
066	American Board of Thoracic Surgery
067	American Board of Urology
142	Boards other than ABMS/AOA

Dental Boards

113	American Board of Endodontics
114	American Board of Oral & Maxillofacial Pathology
117	American Board of Oral & Maxillofacial Radiology
109	American Board of Oral & Maxillofacial Surgeons

108	American Board of Orthodontics
112	American Board of Pediatric Dentistry
111	American Board of Periodontology
115	American Board of Prosthodontics
106	American Board of Public Health Dentistry
120	Boards other than ABMS/AOA

DO Boards

118	American Osteopathic Board of Anesthesiology
119	American Osteopathic Board of Dermatology
120	American Osteopathic Board of Emergency Medicine
121	American Osteopathic Board of Family Practice
123	American Osteopathic Board of Internal Medicine
124	American Osteopathic Board of Neurology and Psychiatry
125	American Osteopathic Board of Neuromuskuloskeletal Medicine
126	American Osteopathic Board of Nuclear Medicine
127	American Osteopathic Board of Obstetrics and Gynecology
128	American Osteopathic Board of Ophthalmology and Otolaryngology
129	American Osteopathic Board of Orthopedic Surgery
130	American Osteopathic Board of Pathology
131	American Osteopathic Board of Pediatrics
132	American Osteopathic Board of Preventive Medicine
133	American Osteopathic Board of Proctology
134	American Osteopathic Board of Radiology
135	American Osteopathic Board of Rehabilitation Medicine
136	American Osteopathic Board of Surgery

DPM Boards

140	American Board of Medical Specialists in Podiatry
137	American Board of Podiatric Orthopedics and Primary Podiatric Medicine
138	American Board of Podiatric Surgery
139	American Council of Certified Podiatric Surgeons and Physicians

KAPER-1 (01/2009)

Part B, Section 1

For Health Care Providers Desiring Initial Hospital or Health Care Facility Privileges

NOTE: Submission and approval of a pre-application for privileges may be required by a health care facility prior to the facility's processing a completed KAPER-1 (01/2009), Part B, Section 1. Therefore, a provider desiring initial health care facility privileges is advised to contact the facility for information relating to any pre-application requirements.

Commonwealth of Kentucky
Instructions - Form (01/2009), Part B, Section 1

A. Uniform Application for Evaluation (Credentialing) Form. Following is the form KAPER-1 (01/2009), Part B, Section 1, developed pursuant to KRS 304.17A-535(5) for evaluation (credentialing) of a health care provider. The form is available on the Web site of the Kentucky Department of Insurance at <http://insurance.ky.gov>. Prior to completing this form, a health care provider who desires initial evaluation (credentialing) by a hospital or health care facility is advised to contact that specific hospital or health care facility for information regarding submission of the complete KAPER-1 (01/2009), Part B, Section 1, and required attachments, as applicable and specified in item C of this instruction.

B. Cover Letter. A cover letter, which is signed and dated by the health care provider who desires evaluation (credentialing) by a hospital or health care facility, requesting consideration of the complete KAPER-1 (01/2009), Part B, Section 1, and required attachments, as applicable and specified in item C of this instruction, may be required.

C. Required Attachments.

For a Physician, unless otherwise specified in this instruction, one (1) photocopy of each of the following supporting documents should be labeled and attached to the complete form KAPER-1 (01/2009), Part B, Section 1, in the following order:

1. Current medical, dental or professional license or evidence of licensure, as applicable (If medical, dental or other health care provider, including a psychologist, has applied for, but not received this license, a copy of the application for this license will be accepted until a copy of the license is available for submission.);
2. Current federal drug enforcement agency (DEA) certificate for each state of practice. (If medical, dental or other health care provider, including a psychologist, has applied for, but not received this number, a copy of the application for a DEA number will be accepted until the DEA number is available for submission.);
3. Current state substance registration certificate, if applicable. (If medical, dental or other health care provider, including a psychologist, has applied for but not received this certificate, a copy of the application for this certificate will be accepted until a copy of the state substance registration certificate is available for submission.);
4. Proof of current professional liability insurance, including name, inception and expiration dates and amount of coverage (If medical, dental or other health care provider, including a psychologist, has applied for but not received professional liability insurance, a photocopy of the application for professional liability insurance will be accepted until the proof of current professional liability insurance is available for submission.);
5. Board certification/eligibility verification information;
6. Curriculum vitae (All time periods from receipt of degree to present must be accounted for);
7. Current photograph;
8. Photo identification (ID). Additionally, photo ID should be presented in person at the hospital or health care organization where participation is desired; and
9. Separate pages or supplemental forms, if any, in page number order.

For an Allied Health Professional, unless otherwise specified in this instruction, one (1) photocopy of each of the following supporting documents should be labeled and attached to the complete form KAPER-1 (01/2009), Part B, Section 1, in the following order:

1. Current professional license or evidence of licensure (If multiple professional licenses are held by the allied health professional, a copy of each license and/or registration should be attached; for example, registered nurse (RN));
2. Current federal drug enforcement agency (DEA) certificate, if applicable for allied health professional specialty (If allied health professional has applied for but not been issued a DEA number, a copy of the application requesting this number may be submitted until a copy of the actual DEA number is available for submission.);
3. Current state substance registration certificate, if applicable (If allied health professional has applied for but not been issued a state substance registration certificate, a copy of the application requesting this certificate may be submitted until a copy of the actual certificate is available for submission.);
4. Statement of sponsoring health care provider (e.g., physician) or collaborative practice agreement, if applicable;
5. Proof of current professional liability insurance, including allied health professional name, inception and expiration date, and amount of coverage (If allied health professional has applied for but not been issued professional liability insurance, a copy of the application requesting coverage may be submitted until a copy of the approval of coverage is available for submission.);
6. Curriculum vitae or resume (All time periods from receipt of degree to present must be accounted for);
7. Current photograph;
8. Photo identification (ID). Additionally, photo ID should be presented in person at the hospital or health care organization where participation is desired; and
9. Separate pages or supplemental forms, if any, in page number order.

I. PERSONAL IDENTIFICATION DATA

Name: _____
Last Suffix First Middle Maiden Name Degree

☐ Medical Staff ☐ Allied Health (please specify) _____

Residence: _____ Phone: _____

_____ Fax: _____

Primary Office Address: _____ Phone: _____

_____ Fax: _____

Secondary Office Address: _____ Phone: _____

_____ Fax: _____

Billing Office Address: _____ Phone: _____

_____ Fax: _____

Credentialing Address: _____ Phone: _____

_____ Fax: _____

Credentialing Contact: _____ Credentialing Email: _____

Preferred Mailing Address: ☐ Primary Office ☐ Residence ☐ Other (please specify) _____

Phys. Email Address: _____ Prac. Admin's Email: _____ Office Web Address: _____

Date of Birth: _____ Gender: _____ Place of Birth: _____

Social Security #: _____ Marital Status: _____

Citizenship: _____ Spouse: _____

(If not a US citizen, please complete the next three fields)

Visa Status: _____ Alien Reg. #: _____ Exp. Date: _____

Language Spoken: _____

ECFMG #: ☐ - ☐☐☐ - ☐☐☐ - ☐ Pager #: _____ ☐ Alpha ☐ Digital ☐ Voice
(if applicable):

Medicare #: _____ Cellular #: _____

Medicaid #: _____ Answering service #: _____

UPIN: _____ Are you taking new patients? _____

EIN: _____ Taxonomy Code: _____

NPI #: _____

Clinical Specialty/Subspecialty: _____

Other interests in practice, research, etc.: _____

Name others with whom you are or will be associated in practice: _____

Nature of association: ☐ Solo ☐ Group ☐ Partnership ☐ Corporation Effective Date: _____

Other: (please specify) _____

Name of Practice (if applicable): _____

Covering physician(s) to be called in my absence (Allied Health Professionals list sponsoring physician):

Name: _____ Specialty: _____ Telephone: _____

Name: _____ Specialty: _____ Telephone: _____

Name: _____ Specialty: _____ Telephone: _____

II. EDUCATIONAL DATA

(All periods of time must be accounted for from entrance into medical school to the present)

Please indicate if your name at any educational institution is different than the name listed on your application. ☐ Yes ☐ No

If YES, please identify other name(s): _____

A. Schools

Undergraduate College/University: _____

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____ / _____
From (mm/yy) To (mm/yy)

Medical/Dental/Other College: _____

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____ / _____
From (mm/yy) To (mm/yy)

B. Internships

Name: _____ / _____
Type of Internship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

During this internship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?

If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

Name: _____ / _____
Type of Internship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

During this internship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?

If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

☐ Check if more than two internships were begun or completed. Please supply the same information on a separate sheet and attach.

C. Residencies

Name: _____ / _____
Type of Residency From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Chairman/Chief of Service: _____

Did you complete the residency? ☐ Yes ☐ No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

Name: _____ / _____
Type of Residency From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Chairman/Chief of Service: _____

Did you complete the residency? ☐ Yes ☐ No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

Name: _____ / _____
Type of Residency From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Chairman/Chief of Service: _____

Did you complete the residency? ☐ Yes ☐ No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

☐ Check if more than three residencies were begun or completed. Please supply the same information on a separate sheet and attach.

D. Fellowship and/or Other Postgraduate Training

Name: _____ / _____
Type of Fellowship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Did you complete the fellowship? ☐ Yes ☐ No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

Name: _____ / _____
Type of Fellowship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Did you complete the fellowship? ☐ Yes ☐ No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?

If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

Name: _____ / _____
Type of Fellowship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Did you complete the fellowship? ☐ Yes ☐ No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?

If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

☐ Check if more than three fellowships were begun or completed. Please supply the same information on a separate sheet and attach.

E. Other Professional Training

School: _____ / _____
Chairman/Chief of Service From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____

School: _____ / _____
Chairman/Chief of Service From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____

☐ Check if more than two training programs were begun or completed. Please supply the same information on a separate sheet and attach.

III. TEACHING APPOINTMENTS

Name: _____
Department Chief Type of Appointment

Address: _____

City/State/ZIP: _____ / _____
City St ZIP ZIP+ From (mm/yy) To (mm/yy)

Phone: _____ Fax: _____ Email (if available): _____

Name: _____
Department Chief Type of Appointment

Address: _____

City/State/ZIP: _____ / _____
City St ZIP ZIP+ From (mm/yy) To (mm/yy)

Phone: _____ Fax: _____ Email (if available): _____

IV. POST-GRADUATE AND CONTINUING EDUCATION COURSES

Have you participated in post-graduate/continuing education courses in the last three years? If YES, please supply an attached list and/or certificate of attendance.

☐ YES ☐ NO ☐ List and/or certificates attached

Do you have a cardio-pulmonary resuscitation certificate?

<input type="checkbox"/> CPR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ACLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ATLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> PALS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> NRP	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____

Please attach copies of all certificates.

V. LICENSURE INFORMATION

List all current and past professional health care licenses held and attach copies of all active licenses. Allied Health Professionals: list all certifications.

State:	License #:	Date Issued:	Expiration Date:	Status:	License Obtained by:
KY State: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #2: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #3: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #4: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #5: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #6: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #7: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #8: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity

If licensed in more than eight (8) states, please supply the same information on a separate sheet and attach.

VI. DRUG ENFORCEMENT ADMINISTRATION INFORMATION (DEA)

(This application cannot be processed without current Federal DEA Certificate for each state in which you practice)

Federal DEA Certificate #: _____ Expiration: _____

Federal DEA Certificate #: _____ Expiration: _____

VII. STATE NARCOTICS REGISTRATION: CONTROLLED SUBSTANCE REGISTRATION (CSR)

Some states require additional CSR certificates. Attach copies of any additional CSR certificates you have.

State: _____

Certificate #: _____ Expiration: _____

State: _____

Certificate #: _____ Expiration: _____

VIII. PROFESSIONAL LIABILITY DATA

(This application cannot be processed without proof of amount of professional liability)

Name of Carrier: _____

Address: _____

City: _____ State: _____ ZIP: _____

Policy #: _____ Amount of Coverage: _____

Date of Inception: _____ Date of Expiration: _____

Name of Agency: _____

☐ CLAIMS MADE ☐ OCCURRENCE (Check One)

Please list any other professional liability carriers you have used within the last five (5) years: _____

Answer the following questions:

- | | | | |
|---|------------------------------|------------------------------|-----------------------------|
| 1. Has your professional liability insurance coverage been terminated by action of the insurance company? | <input type="checkbox"/> N/A | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty? | <input type="checkbox"/> N/A | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Has your present professional liability insurance carrier excluded any specific procedures from your coverage? | <input type="checkbox"/> N/A | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have any professional liability suits or claims been filed against you? | <input type="checkbox"/> N/A | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have any professional liability suits or claims been filed against you which are presently pending? | <input type="checkbox"/> N/A | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Have any judgments or settlements been made against you in professional liability cases? | <input type="checkbox"/> N/A | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. If applying to an Indiana facility, do you participate in the Indiana Patient Compensation Fund? | <input type="checkbox"/> N/A | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. If applying to a Virginia facility, do you participate in the Birth-related Neurological Injury Compensation Act? | <input type="checkbox"/> N/A | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If the answer is yes to any of the above questions, please explain the case(s) and the outcome(s) on the following Professional Liability Detail Sheet. Provide a full explanation including the name of the carrier, the date and specific information concerning any limitation, settlement or judgment.

PROFESSIONAL LIABILITY DETAIL SHEET

(Please copy this page if additional sheets are needed)

☐ CHECK HERE IF NOT APPLICABLE

Please fill in the following details for each pending or settled malpractice suit or claim you have experienced:

☐ Pending ☐ Settled Date: _____

List the allegations: _____

Date of occurrence: _____

Name of institution involved (i.e., hospital): _____

Name and address of insurance carriers involved: _____

Please supply the following details for each malpractice lawsuit in which you were a defendant, and which resulted in a jury award or court judgments against you.

Title of the court case: _____

The court case number: _____

The venue of the case (place where court case took place, such as County District Court or Circuit Court): _____

Allegations listed in complaint: _____

Date of incident leading to complaint: _____

Place of incident: _____

Name and address of malpractice insurance carrier: _____

Amount of jury award or amount awarded by the court: _____

IX. CERTIFICATION BY AMERICAN BOARD OF MEDICAL SPECIALTIES OR AMERICAN OSTEOPATHIC ASSOCIATION

(Allied Health Professional: list national certifications)

- Are you board certified? ☐ Yes ☐ No (If not Board admissible, please explain on separate sheet and attach)
- If yes, list full name of certifying board and date which you obtained certification/recertification:

Date: _____
Date: _____
Date: _____
Date: _____
Date: _____
- If you are not yet certified but have applied to a specialty board for examination, give the name of the board and date of application:
_____ Date: _____
- If status is one of eligibility, provide year when eligibility will terminate under rules of the specific board: _____
- List date of next required recertification (if applicable): _____
- Have you ever been examined by a specialty board but failed to pass the exam? If yes, please explain. ☐ Yes ☐ No

X. INDIVIDUAL PRACTICE INFORMATION

Please answer each of the following questions in full. If the answer to any question is "yes," please provide full explanation of the details on a separate sheet and attach.

- Are there any actions that have been initiated or are any pending against you by any state licensing board? ☐ Yes ☐ No
☐ Pending ☐ Resolved
- Have you had any professional license or certification in any state that has ever been denied, limited, suspended, sanctioned, revoked, probated, voluntarily or involuntarily relinquished or not renewed? ☐ Yes ☐ No
- Have you ever received notice of a proposed or actual exclusion (suspension, sanction, otherwise restricted) from any private health care program(s) or any health care program(s) funded in whole or in part by the state or federal government, including Medicare or Medicaid? If so, provide a detailed description of this matter, including the current status of your participation in such program(s). ☐ Yes ☐ No
- Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? ☐ N/A ☐ Yes ☐ No
- Have your narcotics registration certificates ever been limited, suspended, revoked, voluntarily or involuntarily surrendered or not renewed? ☐ N/A ☐ Yes ☐ No
- If applicable, is your federal (to include District of Columbia and territories of U.S.A.) and/or state narcotics registration certificate being challenged? ☐ N/A ☐ Yes ☐ No
- Have you been named as a defendant or convicted of a felony or misdemeanor? ☐ Yes ☐ No
- Have your employment, medical staff appointment or clinical privileges ever been voluntarily or involuntarily denied, suspended, diminished, revoked, limited or not renewed at any health care facility? ☐ Yes ☐ No
- Have you ever withdrawn your application for appointment, reappointment, clinical privileges, or resigned from the medical staff of any health care facility before a decision was made by its governing board? ☐ Yes ☐ No
- Have you ever been the subject of disciplinary proceedings or a focus review based on inappropriate quality of care at any hospital or health care facility? ☐ Yes ☐ No
- Have you ever been denied membership or renewal thereof, or been subject to disciplinary or adverse action in any medical or professional organization? ☐ Yes ☐ No

XI. PERSONAL HEALTH STATUS

Please answer each of the following questions in full. If the answer to any question is "yes," please provide full explanation of the details on the appropriate Explanation Sheet.

- Can you perform any and all of the procedures, provide the treatment for which you have requested clinical privileges, and meet the requirements of medical staff membership, with or without reasonable accommodation? ☐ Yes ☐ No
- Please describe how you will perform any and all of the procedures, provide the treatment for which you have requested clinical privileges, and meet the requirements of medical staff membership? (attach additional sheets if necessary)

XII. PROFESSIONAL SOCIETIES

Membership in local, state, or national medical societies

Dates

Name: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____
City: _____ State: _____ ZIP: _____

Name: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____
City: _____ State: _____ ZIP: _____

Name: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____
City: _____ State: _____ ZIP: _____

Name: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____
City: _____ State: _____ ZIP: _____

1. I would like to use this application for membership in the _____ County Medical Society and the KMA.
A separate dues statement will be sent.

2. I am already a member of my local medical society. Please specify society: _____

XIII. PROFESSIONAL EMPLOYMENT AND AFFILIATIONS

A. Employment

List in chronological order all professional employment since completion of post-graduate education, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____ Type of Privileges/Position: _____

City/St/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____ Type of Privileges/Position: _____

City/St/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____ Type of Privileges/Position: _____

City/St/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

B. Affiliations

List in chronological order all professional affiliations since completion of post-graduate education, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

XIV. PEER REFERENCES

Name three physicians who have personal knowledge of your current clinical abilities, and ethical character, who will provide specific written comments on these matters upon request from Hospitals, Medical Societies, or Authorized Credentialing Services. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time, and at least one must have had organizational responsibility for your performance. The individuals should not be related to you by blood or marriage, training directors, partners/associates in your current group practice, or anyone with whom you have or anticipate having a financial relationship. Requested sources: practitioner in same specialty or practitioners with whom you have a referral pattern. If you recently completed training, you may use chief resident or other training colleague. Allied Health Professional should list their sponsoring physician, another physician and one peer from the same specialty as the applicant. Please note that you may be required to follow further directions of an individual hospital or facility in order to accommodate variations in medical staff bylaws.

Reference: _____

Address: _____

City/St/ZIP: _____ Country: _____

Phone: _____ Fax: _____ Email (if available): _____

Reference: _____

Address: _____

City/St/ZIP: _____ Country: _____

Phone: _____ Fax: _____ Email (if available): _____

Reference: _____

Address: _____

City/St/ZIP: _____ Country: _____

Phone: _____ Fax: _____ Email (if available): _____

XV. AUTHORIZATION AND RELEASE OF APPLICANT (HEALTHCARE FACILITY RELEASE)

(Please read carefully before signing)

As a condition of applying for/accepting medical staff appointment or clinical privileges at the healthcare facilities listed in this application ("Hospital"), and whether or not my application is accepted, I acknowledge, consent, and agree as follows:

A) I extend absolute immunity to, and release from all liability, the Hospital, its authorized representatives, and third parties (as defined in subsection C below), for any good faith communications, recommendations, disclosures or administrative action involving and pertaining to: (1) applications for appointment, reappointment or clinical privileges; (2) periodic reappraisals; (3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, reappointment, or any other disciplinary action; (4) summary suspensions; (5) hearings and appellate reviews; (6) care evaluations; (7) utilization reviews; (8) any other healthcare facility, medical staff, department, service or committee activities; (9) my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and (10) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of the Hospital.

B) I will make myself available for interviews and acknowledge the burden of producing updated current information as to all questions on this application and such other information reasonably necessary to evaluate my qualifications. The Hospital and its authorized representatives may consult with and obtain information, including otherwise privileged or confidential information, from the Hospital's medical staff appointees and employees and from any third party bearing on my professional qualifications, all matters listed in subsection A, and any other matters bearing on my satisfaction of the criteria for reappointment to the medical staff. I authorize all persons and organizations having any knowledge of such matters to release said information to the Hospital or its authorized representatives upon request and I consent to the reporting of disciplinary information described below in section C.

C) The term "Hospital and its authorized representatives" means the Hospital, its governing entity, persons who have any responsibility for or knowledge pertaining to the matters outlined in subsection A above, and authorized Centralized Verification Organization (CVO). The term "third party" means any individual, including a reappointee to the medical staff or other healthcare facilities, other physicians and health practitioners, government agencies, professional liability insurers, and other entities from whom or by whom the Hospital, authorized CVO, or other authorized representatives have requested or supplied information pertaining to matters in subsection A above.

I acknowledge and agree that: (1) medical staff reappointment and clinical privileges are not a right; (2) applications and requests will be evaluated in accordance with prescribed procedures defined in the Hospital and medical staff bylaws, rules and regulations; (3) I shall be bound by the medical staff bylaws, rules and regulations, and corporate compliance programs, as amended from time to time, of hospitals to which I now and may subsequently apply; (4) I pledge to provide for continuous care for my patients in the hospital; (5) Hospital or its authorized representatives and third parties acting in their official capacities will notify authorized CVO and appropriate governmental agencies, boards or professional associations of disciplinary or professional action taken with respect to me if required to be reported to the Kentucky Medical Licensure Board by KRS 311.606 or if required to be reported by the authorized CVO, by medical staff bylaws, or by any other state or federal law; and (6) that this authorization, attestation and release is irrevocable for any period during which I am an applicant for or have medical staff privileges at Hospital, or, if later in time, for as long as Hospital may be under a duty to report information pursuant to the Health Care Quality Improvement Act of 1986. Pub. L. 99-660.

I represent and warrant that at the time of this application and at all times while I maintain medical staff membership that (1) I am not nor have I ever been, excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid; (2) I have not been convicted under any state or federal law of any offense for which I could face mandatory exclusion from participation in any state or federal health care program, including Medicare and Medicaid; (3) I have not committed any act for which I may be permissibly excluded from participation in any state or federal health care program, including Medicare and Medicaid; (4) I do not hold, and have never held, a direct or indirect ownership or controlling interest of five percent (5%) or more in any entity that has been excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid, nor have I ever been an officer, director, agent, or managing employee of any such entity; and (5) I have never been convicted of a federal health care offense as defined in 18 U.S.C. § 24, including any theft, embezzlement, fraud, or other acts as prohibited therein with regard to any public or private health plan. I agree to notify Hospital immediately in the event I am unable to maintain one or more of these representations.

D) Information and documents derived from or compiled in connection with matters listed in subsection A above, shall be privileged and confidential to the fullest extent permitted by law.

Information contained in or attached to this application is accurate and complete to the best of my knowledge. Any misrepresentation, misstatement, or omission, whether intentional or not, may constitute cause for immediate rejection of this application and termination of any status or privilege granted in reliance upon it.

Applicant's Signature: _____

Date: _____

ACKNOWLEDGEMENT STATEMENT

The following statement is required (by Medicare/Champus regulation) to be signed by each physician when he/she joins the Medical Staff. This must be signed and dated in the physician's own handwriting using his/her legal signature (initials are not accepted).

According to federal guidelines, stamped signatures and typed dates are not acceptable.

MEDICARE/CHAMPUS

"Notice to physicians: Medicare/Champus payment to hospitals is based in part on each patient's principle and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment or civil penalty under applicable federal law."

I certify that I have received the above statement.

Signature: _____ Date: _____

Type or Printed Name: _____

KAPER-1 (01/2009)
Part B, Section 2

**For Health Care Providers Desiring Reevaluation
for Hospital or Health Care Facility Privileges**

Commonwealth of Kentucky
Instructions - KAPER-1 (01/2009), Part B, Section 2

A. Uniform Application for Reevaluation (Recredentialing) Form. Following is the KAPER-1 (01/2009), Part B, Section 2 developed pursuant to KRS 304.17A-545(5) for reevaluation (recredentialing) of health care providers. The form is available on the Web site of the Kentucky Department of Insurance at <http://insurance.ky.gov>. Prior to completing this form, a health care provider who desires reevaluation (recredentialing) by a hospital or health care facility is advised to contact that specific hospital or health care facility for information regarding submission of the complete KAPER-1 (01/2009), Part B, Section 2 and required attachments, as applicable and specified in item C of this instruction.

B. Cover Letter. A cover letter, which is signed and dated by the provider, who desires reevaluation (recredentialing) by a hospital or health care facility, requesting consideration of the complete KAPER-1 (01/2009), Part B, Section 2 and required attachments, as applicable and specified in item C of this instruction, may be required.

C. Required Attachments. Unless otherwise specified in this instruction, one (1) photocopy of each of the following supporting documents should be labeled and attached to the complete form KAPER-1 (01/2009), Part B, Section 2 in the following order:

1. Current medical, dental or professional license or evidence of licensure, as applicable;
2. Current federal drug enforcement agency (DEA) certificate for each state of practice;
3. Current state substance registration certificate, as applicable;
4. Proof of current professional liability insurance, including name, limits of liability and expiration dates. Additionally, if an affirmative response is entered for any question in Section VII of this section, provide a written explanation on an additional page of this attachment;
5. Proof of continuing medical education (CME) or continuing education unit (CEU) credits obtained in the past two (2) years; and
6. Separate pages, as applicable, in page number order.

I. PERSONAL IDENTIFICATION DATA

Name: _____

Last	Suffix	First	Middle	Maiden Name	Degree
------	--------	-------	--------	-------------	--------

☐ Medical Staff ☐ Allied Health (please specify) _____

Residence: _____ Phone: _____
 _____ Fax: _____

Primary Office Address: _____ Phone: _____
 _____ Fax: _____

Secondary Office Address: _____ Phone: _____
 _____ Fax: _____

Billing Office Address: _____ Phone: _____
 _____ Fax: _____

Credentialing Address: _____ Phone: _____
 _____ Fax: _____

Credentialing Contact: _____ Credentialing Email: _____

Preferred Mailing Address: ☐ Primary Office ☐ Residence ☐ Other (please specify) _____

Phys. Email Address: _____ Prac. Admin's Email: _____ Office Web Address: _____

Date of Birth: _____ Gender: _____ Place of Birth: _____

Social Security #: _____ Marital Status: _____

Citizenship: _____ Spouse: _____

(If not a US citizen, please complete the next three fields)

Visa Status: _____ Alien Reg. #: _____ Exp. Date: _____

Language Spoken: _____

ECFMG #: ☐ - ☐☐☐ - ☐☐☐ - ☐ Pager #: _____ ☐ Alpha ☐ Digital ☐ Voice
(if applicable):

Medicare #: _____ Cellular #: _____

Medicaid #: _____ Answering service #: _____

UPIN: _____ Are you taking new patients? _____

EIN: _____ Taxonomy Code: _____

NPI #: _____

Clinical Specialty/Subspecialty: _____

Other interests in practice, research, etc.: _____

Name others with whom you are or will be associated in practice: _____

Nature of association: ☐ Solo ☐ Group ☐ Partnership ☐ Corporation Effective Date: _____

Other: (please specify) _____

Name of Practice (if applicable): _____

Covering physician(s) to be called in my absence (Allied Health Professionals list sponsoring physician):

Name: _____ Specialty: _____ Telephone: _____

Name: _____ Specialty: _____ Telephone: _____

Name: _____ Specialty: _____ Telephone: _____

II. TEACHING APPOINTMENTS

Name: _____ Department Chief _____ Type of Appointment _____

Address: _____

City/State/ZIP: _____ / _____

City _____ St _____ ZIP _____ ZIP+ _____ From (mm/yy) _____ To (mm/yy) _____

Phone: _____ Fax: _____ Email (if available): _____

III. POST-GRADUATE AND CONTINUING EDUCATION COURSES

Have you participated in post-graduate/continuing education courses in the last two (2) years? If YES, please supply an attached list and/or certificate of attendance.

☐ YES ☐ NO ☐ List and/or certificates attached

Do you have a cardio-pulmonary resuscitation certificate?

<input type="checkbox"/> CPR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ACLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ATLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> PALS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> NRP	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____

Please attach copies of all certificates.

IV. LICENSURE INFORMATION

List all current and past professional health care licenses held and attach copies of all active licenses. Allied Health Professionals: list all certifications.

State:	License #:	Date Issued:	Expiration Date:	Status:	License Obtained by:
KY State:	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #2:	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #3:	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #4:	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #5:	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #6:	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #7:	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #8:	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity

If licensed in more than eight (8) states, please supply the same information on a separate sheet and attach.

V. DRUG ENFORCEMENT ADMINISTRATION INFORMATION (DEA)

(This application cannot be processed without current Federal DEA Certificate for each state in which you practice)

Federal DEA Certificate #: _____ Expiration: _____

Federal DEA Certificate #: _____ Expiration: _____

VI. STATE NARCOTICS REGISTRATION: CONTROLLED SUBSTANCE REGISTRATION (CSR)

Some states require additional CSR certificates. Attach copies of any additional CSR certificates you have.

State: _____

Certificate #: _____ Expiration: _____

State: _____

Certificate #: _____ Expiration: _____

VII. PROFESSIONAL LIABILITY DATA

Answer the following questions as they apply to the last two (2) years:

- | | | |
|---|------------------------------|--|
| 1. Has your professional liability insurance coverage been terminated by action of the insurance company? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Has your present professional liability insurance carrier excluded any specific procedures from our coverage? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have any professional liability suits or claims been filed against you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have any professional liability suits or claims been filed against you which are presently pending? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Have any judgments or settlements been made against you in professional liability cases? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. If applying to an Indiana facility, do you participate in the Indiana Patient Compensation Fund? | <input type="checkbox"/> N/A | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. If applying to a Virginia facility, do you participate in the Birth-related Neurological Injury Compensation Act? | <input type="checkbox"/> N/A | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If the answer is yes to any of the above questions, please explain the case(s) and the outcome(s) on the following Professional Liability Detail Sheet. Provide a full explanation including the name of the carrier, the date and specific information concerning any limitation, settlement or judgment.

PROFESSIONAL LIABILITY DETAIL SHEET

(Please copy this page if additional sheets are needed)

☐ CHECK HERE IF NOT APPLICABLE

Please fill in the following details for each pending or settled malpractice suit or claim you have experienced:

☐ Pending ☐ Settled Date: _____

List the allegations: _____

Date of occurrence: _____

Name of institution involved (i.e., hospital): _____

Name and address of insurance carriers involved: _____

Please supply the following details for each malpractice lawsuit in which you were a defendant, and which resulted in a jury award or court judgments against you.

Title of the court case: _____

The court case number: _____

The venue of the case (place where court case took place, such as County District Court or Circuit Court): _____

Allegations listed in complaint: _____

Date of incident leading to complaint: _____

Place of incident: _____

Name and address of malpractice insurance carrier: _____

Amount of jury award or amount awarded by the court: _____

VIII. CERTIFICATION BY AMERICAN BOARD OF MEDICAL SPECIALTIES OR AMERICAN OSTEOPATHIC ASSOCIATION

(Allied Health Professional: list national certifications)

1. Are you board certified? ☐ Yes ☐ No (If not Board admissible, please explain on separate sheet and attach)
2. If yes, list full name of certifying board and date which you obtained certification/recertification:

Date: _____
Date: _____
Date: _____
Date: _____
3. If you are not yet certified but have applied to a specialty board for examination, give the name of the board and date of application:
_____ Date: _____
4. If status is one of eligibility, provide year when eligibility will terminate under rules of the specific board: _____
5. List date of next required recertification (if applicable): _____
6. Have you ever been examined by a specialty board but failed to pass the exam? If yes, please explain. ☐ Yes ☐ No

IX. INDIVIDUAL PRACTICE INFORMATION

Please answer each of the following questions in full AS THEY PERTAIN TO THE LAST TWO YEARS. If the answer to any question is "yes," please provide full explanation of the details on a separate sheet and attach.

1. Are there any actions that have been initiated or are any pending against you by any state licensing board?
☐ Pending ☐ Resolved ☐ Yes ☐ No
2. Have you had any professional license or certification in any state that has ever been denied, limited, suspended, sanctioned, revoked, probated, voluntarily or involuntarily relinquished or not renewed? ☐ Yes ☐ No
3. Have you ever received notice of a proposed or actual exclusion (suspension, sanction, otherwise restricted) from any private health care program(s) or any health care program(s) funded in whole or in part by the state or federal government, including Medicare or Medicaid? If so, provide a detailed description of this matter, including the current status of your participation in such program(s). ☐ Yes ☐ No
4. Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? ☐ N/A ☐ Yes ☐ No
6. Have your narcotics registration certificates ever been limited, suspended, revoked, voluntarily or involuntarily surrendered or not renewed? ☐ N/A ☐ Yes ☐ No
6. If applicable, is your federal (to include District of Columbia and territories of U.S.A.) and/or state narcotics registration certificate being challenged? ☐ N/A ☐ Yes ☐ No
7. Have you been named as a defendant or convicted of a felony or misdemeanor? ☐ Yes ☐ No
8. Have your employment, medical staff appointment or clinical privileges ever been voluntarily or involuntarily denied, suspended, diminished, revoked, limited or not renewed at any health care facility? ☐ Yes ☐ No
9. Have you ever withdrawn your application for appointment, reappointment, clinical privileges, or resigned from the medical staff of any health care facility before a decision was made by its governing board? ☐ Yes ☐ No
10. Have you ever been the subject of disciplinary proceedings or a focus review based on inappropriate quality of care at any hospital or health care facility? ☐ Yes ☐ No
11. Have you ever been denied membership or renewal thereof, or been subject to disciplinary or adverse action in any medical or professional organization? ☐ Yes ☐ No

X. PERSONAL HEALTH STATUS

Please answer each of the following questions in full AS THEY PERTAIN TO THE LAST TWO YEARS. If the answer to any question is "yes," please provide full explanation of the details on the appropriate Explanation Sheet.

1. Can you perform any and all of the procedures, provide the treatment for which you have requested clinical privileges, and meet the requirements of medical staff membership, with or without reasonable accommodation? ☐ Yes ☐ No
2. Please describe how you will perform any and all of the procedures, provide the treatment for which you have requested clinical privileges, and meet the requirements of medical staff membership? (attach additional sheets if necessary)

XI. PROFESSIONAL EMPLOYMENT AND AFFILIATIONS

A. Employment

List in chronological order all professional employment within the past two (2) years, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

B. Affiliations

List in chronological order all professional affiliations within the past two (2) years, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/St/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

XII. PEER REFERENCES

Name two peers who have personal knowledge of your current clinical abilities, ethical character, who will provide specific written comments on these matters upon request from Hospitals, Medical Societies, or Authorized Credentialing Services. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time, and at least one must have had organizational responsibility for your performance. The individuals should not be related to you by blood or marriage, training directors, partners/associates in your current group practice, or anyone with whom you have or anticipate having a financial relationship. Requested sources: practitioner in same specialty or practitioners with whom you have a referral pattern. If you recently completed training, you may use chief resident or other training colleague. Allied Health Professional should list their sponsoring physician, another physician and one peer from the same specialty as the applicant. Please note that you may be required to follow further directions of an individual hospital or facility in order to accommodate variations in medical staff bylaws.

Reference: _____
Address: _____
City/St/ZIP: _____ Country: _____
Phone: _____ Fax: _____ Email (if available): _____

Reference: _____
Address: _____
City/St/ZIP: _____ Country: _____
Phone: _____ Fax: _____ Email (if available): _____

XIII. AUTHORIZATION AND RELEASE OF APPLICANT (HEALTHCARE FACILITY RELEASE)

(Please read carefully before signing)

As a condition of applying for/accepting medical staff appointment or clinical privileges at the healthcare facilities listed in this application ("Hospital"), and whether or not my application is accepted, I acknowledge, consent, and agree as follows:

A) I extend absolute immunity to, and release from all liability, the Hospital, its authorized representatives, and third parties (as defined in subsection C below), for any good faith communications, recommendations, disclosures or administrative action involving and pertaining to: (1) applications for appointment, reappointment or clinical privileges; (2) periodic reappraisals; (3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, reappointment, or any other disciplinary action; (4) summary suspensions; (5) hearings and appellate reviews; (6) care evaluations; (7) utilization reviews; (8) any other healthcare facility, medical staff, department, service or committee activities; (9) my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and (10) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of the Hospital.

B) I will make myself available for interviews and acknowledge the burden of producing updated current information as to all questions on this application and such other information reasonably necessary to evaluate my qualifications. The Hospital and its authorized representatives may consult with and obtain information, including otherwise privileged or confidential information, from the Hospital's medical staff appointees and employees and from any third party bearing on my professional qualifications, all matters listed in subsection A, and any other matters bearing on my satisfaction of the criteria for reappointment to the medical staff. I authorize all persons and organizations having any knowledge of such matters to release said information to the Hospital or its authorized representatives upon request and I consent to the reporting of disciplinary information described below in section C.

C) The term "Hospital and its authorized representatives" means the Hospital, its governing entity, persons who have any responsibility for or knowledge pertaining to the matters outlined in subsection A above, and authorized Centralized Verification Organization (CVO). The term "third party" means any individual, including a reappointee to the medical staff or other healthcare facilities, other physicians and health practitioners, government agencies, professional liability insurers, and other entities from whom or by whom the Hospital, authorized CVO, or other authorized representatives have requested or supplied information pertaining to matters in subsection A above.

I acknowledge and agree that: (1) medical staff reappointment and clinical privileges are not a right; (2) applications and requests will be evaluated in accordance with prescribed procedures defined in the Hospital and medical staff bylaws, rules and regulations; (3) I shall be bound by the medical staff bylaws, rules and regulations, and corporate compliance programs, as amended from time to time, of hospitals to which I now and may subsequently apply; (4) I pledge to provide for continuous care for my patients in the hospital; (5) Hospital or its authorized representatives and third parties acting in their official capacities will notify authorized CVO and appropriate governmental agencies, boards or professional associations of disciplinary or professional action taken with respect to me if required to be reported to the Kentucky Medical Licensure Board by KRS 311.606 or if required to be reported by the authorized CVO, by medical staff bylaws, or by any other state or federal law; and (6) that this authorization, attestation and release is irrevocable for any period during which I am an applicant for or have medical staff privileges at Hospital, or, if later in time, for as long as Hospital may be under a duty to report information pursuant to the Health Care Quality Improvement Act of 1986. Pub. L. 99-660.

I represent and warrant that at the time of this application and at all times while I maintain medical staff membership that (1) I am not nor have I ever been, excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid; (2) I have not been convicted under any state or federal law of any offense for which I could face mandatory exclusion from participation in any state or federal health care program, including Medicare and Medicaid; (3) I have not committed any act for which I may be permissibly excluded from participation in any state or federal health care program, including Medicare and Medicaid; (4) I do not hold, and have never held, a direct or indirect ownership or controlling interest of five percent (5%) or more in any entity that has been excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid, nor have I ever been an officer, director, agent, or managing employee of any such entity; and (5) I have never been convicted of a federal health care offense as defined in 18 U.S.C. § 24, including any theft, embezzlement, fraud, or other acts as prohibited therein with regard to any public or private health plan. I agree to notify Hospital immediately in the event I am unable to maintain one or more of these representations.

D) Information and documents derived from or compiled in connection with matters listed in subsection A above, shall be privileged and confidential to the fullest extent permitted by law.

Information contained in or attached to this application is accurate and complete to the best of my knowledge. Any misrepresentation, misstatement, or omission, whether intentional or not, may constitute cause for immediate rejection of this application and termination of any status or privilege granted in reliance upon it.

Applicant's Signature: _____

Date: _____